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**‘Creative Risk’: An IPA study of
psychologist’s experiences of and
perspectives about working with
substance misusers with histories of
complex trauma.**

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Submitted in part fulfilment of the degree of doctorate in
Clinical Psychology at the University of Edinburgh

August 2012

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ACKNOWLEDGEMENTS

The people I would like to thank first and foremost are the participants who took part in this study, who generously gave me their time. I hope that their stories can inspire further work in the field and plant the seeds of change.

Thank you also to my academic supervisors, Professor Mick Power, for providing me with useful advice, validation and support and Dr Ethel Quayle and for her expertise on qualitative research methods and her enthusiasm.

Also to my clinical supervisor Dr Sheilagh Hynd who has been a support and inspiration both during the research process and throughout my training. Without her this project would not have gotten off the ground.

Thanks need to go to NHS Lothian for a wonderful training experience including a number of excellent supervisors, all of which I learnt something from, and especially to my trainee peers for being so supportive and hilarious throughout.

Thank you lastly to an amazing bunch of friends, particularly Anne-Marie Purcell , Jessica Trotter, Ian Gilmartin, Charlie Monro and Petra Anderton-Tyers, each of whom in their own way have supported and encouraged me throughout the process of writing my thesis and to whom I am very grateful.

Also thank you to my mum and dad for their endless love and support in everything I do; and my wonderful boyfriend Pete who has managed to make me laugh even when my stress levels were through the roof, he has been my very patient rock

Abstract

Creative Risk: An IPA study of psychologist's experiences of and perspectives about working with substance misusers with histories of complex trauma.

Background: A history of complex trauma alters basic self-structure, attachment system and core areas of interpersonal functioning and relationships. There is increasing recognition of the high proportions of complex trauma histories within substance misusers and limited research into the sequelae of complex trauma, particularly in relation to comorbid complex trauma and substance misuse. There is a distinct lack of adequate theory and guidelines for treatment. **Research Aim:** to explore psychologist's experiences of and perspectives about their work with substance misusers with a history of complex trauma. Complex trauma is a term used to describe experience's which arise from severe, prolonged and repeated trauma which is often interpersonal in nature. Courtois & Ford (2009) have defined complex trauma as *"involving stressors that: are repetitive or prolonged, involve direct harm and/or neglect and abandonment by ostensibly responsible adults, occur at developmentally vulnerable times in the victim's life, such as early childhood, have great potential to compromise severely a child's development."* (p1). The prototype trauma that was first described under the term complex trauma was child abuse and neglect. **Method:** Semi-structured interviews were conducted with eleven clinical and counselling substance misuse psychologists working across four health boards in Central Scotland. The data was analysed using Interpretative Phenomenological Analysis (IPA). **Results:** Six main superordinate themes emerged from the data: 1. Challenges in negotiating therapeutic relationship; 2. Balancing relational forces; 3. Walking the tightrope of comorbidity; 4. Conceptual dearth (surrounding complex trauma); 5. Emotional impact of Work, and, 6. Core role of therapeutic relationship (in treatment and recovery). **Discussion:** Participants accounts suggest there are many risks to balance as well as paradoxes inherent in this type of work. The nature of a history of complex trauma means that often clients have difficulties with attachment and relational aspects in their lives, which in turn affect their engagement in the therapeutic relationship. The findings of this study suggest that it is precisely *because* relationships seem so threatening and challenging for these clients, that the therapeutic relationship appears to form such a vital role in the therapeutic treatment and recovery process for these client.

1 Introduction

Substance misuse is a national and increasing public health problem and addressing substance misuse is a key government priority. It is associated with significant detrimental physical, emotional, economic, social and family outcomes, affecting large numbers of people. It is well-established that a history of trauma is a key correlate of substance misuse problems and may complicate and negatively influence the course and outcome of substance misuse treatment. Traditionally research in the area of co-occurring substance misuse and trauma has focused solely on traumatic syndromes that fit into the diagnostic category of Post-Traumatic Stress Disorder (PTSD). However, recent research has suggested that this method of conceptualising trauma may not fully address the differing ways in which individual's experience the aftermath of trauma, nor may it adequately target the complex pathways by which exposure to trauma can exert its negative effects. After a long history of professional and social denial of its existence, it was not until the 1980's that the literature started to discuss child abuse and its long term sequelae (Herman, 1992a). It took more than fifteen years for the trauma field, and society as a whole to begin to respect childhood abuse, neglect and incest as independent treatment issues.

Reflecting on its often long-term and developmental aetiology, individual's presentations after exposure to more complex types of trauma can include chronic difficulties in identity, sense of self, boundary awareness, emotion regulation and interpersonal and intrapersonal relatedness. The recognition of a range of problems associated with a history of more complex types of trauma is an important development with much relevance for the field of substance misuse; traumatised individuals may have to rely on external ways of reducing abuse related distress. Such behaviours may include substance misuse (Grilo *et al.*, 1997), which may further increase the likelihood of further trauma and further negative outcomes (Acierno *et al.*, 1999).

The absence of clear guidelines or treatment protocols for this population has led to an increasing number of clients cycling in and out of treatment. There is some consensus amongst professionals that until treatment focuses on the underlying issues with self, identity and relationships that are prominent for these individuals this 'revolving door' of treatment experience will continue (Najavits, 2006). Government documents such as

‘Closing the Gaps-Making a Difference: Commitment 13’ (Scottish Government, 2007) and the recent drive for trauma informed services recognise the needs of individuals with co-morbid substance misuse with trauma histories, and this research intends to build on this. This study explores the experiences and perspectives of NHS specialist addiction psychologists working with substance misusers who have a history of complex trauma.

1.1 Definition of Substance misuse.

The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV: American Psychological Association, 1994) defines substance use disorder (SUD) as a collective term for substance abuse and substance dependence. Substance abuse is characterised by repeated use of alcohol or other psychoactive substances, despite this resulting in significant clinical impairment or distress, however the use is not compulsive and there is no evidence of physical dependency (i.e. tolerance or withdrawal on cessation). Substance dependence typically involves three or more features over a twelve month period of: compulsion to use; unsuccessful attempts to control or reduce use; preoccupation with obtaining and using substances, persisting with use despite negative consequences; increased tolerance; physical withdrawal. This research will be using the term substance misuse which includes both substance abuse and dependence and is defined as ‘intoxication by – or regular excessive consumption of and/or dependence on – psychoactive substances, leading to social, psychological, physical or legal problems, and includes problematic use of both legal and illegal drugs’ (National Institute for Clinical Excellence (NICE), 2007). Substance misuse is associated with a range of physical, psychological and social problems which affect individuals and their families and communities. These include psychological problems, social problems, physical health difficulties and criminality (Gossop *et al.*, 1998). The use of alcohol and/or drugs is usually considered ‘substance misuse’ when its use is excessive or inappropriate and it starts to result in associated difficulties in the bio-psycho-social domains of an individual’s life and possibly dependence on the substance (Wiechelt, 2007). Unless otherwise noted, the term substance misuse will be here after be used for all substance use disorders.

1.1.1 Definition of Post-Traumatic Stress Disorder (PTSD)

PTSD is currently considered an anxiety disorder the hallmark of which is a pattern of representative symptoms following exposure to a traumatic event. The experience of such

an event (referred to as a Criterion A event) is the first of several diagnostic criteria for PTSD. To be given a diagnosis of PTSD, an individual has to have been exposed to an extreme stressor or traumatic event where that individual or another person suffers severe physical injury or their own or another's life is in danger (Criterion A). The core phenomenology of PTSD as laid out in the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV APA, 1994) relates to symptoms in three overarching domains including: re-experiencing of the event in the form of 'flashbacks' and nightmares (Criterion B), avoidance of reminders of the event and emotional numbing (Criterion C), and hyper-arousal (Criterion D). Re-experiencing of the event signifies unwelcome recollections of the incident in the form of distressing images, nightmares, or flashbacks. Symptoms of avoidance refer to efforts to avoid reminders of the event, including places, persons or thoughts associated with the incident. Symptoms of hyper-arousal consist of physiological manifestations, such as insomnia, irritability, impaired concentration, hyper-vigilance, and increased startle reactions. In addition, to receive a diagnosis of PTSD, symptoms must persist for more than one month (Criterion E) and must cause clinically significant distress or impairment in functioning (Criterion F).

1.1.2 The differences between PTSD and more complex types of traumatic psychopathology

"In general, the diagnostic concepts of the existing psychiatric canon, including simple PTSD, are not designed for survivors of prolonged, repeated trauma, and do not fit them well" (Herman, 1992a, p388).

The diagnosis of PTSD was first formally used in 1980 when it was included in the third edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-III, American Psychiatric Association, 1980). Whilst there has been some debate into the nature of PTSD (Spitzer *et al.*, 2007) it has been found to be a useful and unifying diagnostic construct which has been applied to many individuals who have been exposed to trauma (van der Kolk, *et al.*, 2009). The origins of the criteria for PTSD were derived from a sparse literature on 'traumatic neuroses' which came mainly from the study of adult males who had been exposed to war trauma (Kardiner, 1941; Scott, 1990). Yet in comparison, few resources have been devoted to research on focusing childhood trauma (Perry, *et al.*, 1995). A large body of research examining the effects of trauma on psychological

functioning has shown that PTSD does not exhaustively define the dimensions of trauma (Breslau *et al.*, 1991; Cole & Putnum, 1992; Herman, 1992b; Kroll *et al.*, 1989). The triad of the symptoms of hyperarousal, avoidance and re-experiencing encapsulated in the PTSD diagnosis, are not always exhibited by individuals who have been traumatised in childhood (Finkelhor 1990; Murphy *et al.*, 1988). One of the limitations of a PTSD conceptualisation of childhood abuse is that it does not adequately consider the interpersonal and relational context of the abuse. Additionally, criteria for the source of an extreme stressor or traumatic event required for PTSD diagnosis does not fit with some types of abuse or neglect where there may be no risk of physical harm or death, but instead risk for profound psychic harm (Finkelhor, 1987; Murphy *et al.*, 1988).

While the symptomatology of victims of single-incident traumas are fairly well captured in the DSM-IV diagnosis of PTSD, victims of chronic, interpersonal trauma frequently present with more severe and pervasive psychological consequences (Briere & Spinazzola, 2009; Chu & Dill, 1990; Cole & Putnam, 1992; Herman, 1992a; Herman *et al.*, 1989; Kroll *et al.*, 1989; Saxe *et al.*, 1993; Van der Kolk, Roth, *et al.*, 2005), which despite being posttraumatic in nature are significantly different from PTSD as defined in the DSM III and IV (APA, 1980, 1994). Frequently these psychological difficulties have been referred to as “comorbid conditions” of PTSD (Foa *et al.*, 2000). However, it has been noted in multiple studies that PTSD has a high rate of ‘comorbidity’ with other disorders (Chu, 2011; Mueser *et al.*, 1998; Saxe *et al.*, 1993). For example, the National Comorbidity Study (Kessler *et al.*, 1995) found that individuals with PTSD were eight times more likely to have had three or more additional disorders than individuals who were not diagnosed with PTSD. Thus, rather than conceptualising these difficulties as co-morbid problems and relegating them to a variety of disorders seemingly separate from a history of trauma, many clinicians and researchers have argued that, instead, they should be considered as a central part of the spectrum of trauma-related problems (Herman, 1992, 2009; Horowitz, 1986; Roth *et al.*, 1997; Van der Kolk *et al.*, 2005). In a consensus statement, leaders within the field of psychological trauma noted that PTSD is not representative of the typical presentation of individuals with trauma histories who are seeking treatment (Ballenger *et al.*, 2000). A review of treatment outcome studies highlights how many patients with the most severe “comorbidities” drop out of traditional PTSD treatment (McDonagh-Coyle, Freidman, McHugo *et al.*, 2005). Separate research found that the archetypal individual frequently screened out of PTSD research because of their numerous comorbid conditions may actually be representative of

the typical patient presenting to mental health services (Spinnazzola, Balunstein & Van der Kolk, 2005).

In response to the profusion of documented adaptations to interpersonal trauma out-with the diagnosis of PTSD, a DSM-IV field trial was conducted between 1991 and 1992 to investigate the effects of chronic interpersonal trauma (Roth *et al.*, 1997). The results of this lent support to the reality of a coherent, complex adaptation to interpersonal maltreatment in children and adults, which was specific to trauma and showed high construct validity (Roth *et al.*, 1997). The new conceptualisation was named “disorders of extreme stress not otherwise specified” (DESNOS), (Pelcovitz *et al.*, 1997) or complex PTSD (Herman, 1992a; 1992b). A criteria set was formulated (Pelcovitz *et al.*, 1997; Van der Kolk *et al.*, 2005) where alterations in the following psychological and relational systems were identified as being central to complex PTSD/DESNOS: 1) regulation of affect and impulses, 2) attention and consciousness, 3) self- perception, 4) relations with others, 5) somatic functioning (i.e., somatisation) and 6) systems of meaning (e.g., hopelessness) (Herman, 1992a; 1992b; Van der Kolk *et al.*, 2005). Despite this symptom constellation having been identified in numerous research studies, DESNOS/complex PTSD is not currently a distinct diagnosis in DSM IV, but is incorporated under “associated and descriptive features” of PTSD (APA, 1994, p425). The ICD-10 has however described the “lasting personality changes following catastrophic stress” (The World Health Organisation (WHO), 1992 p232). DESNOS/ complex PTSD encompasses an extensive set of self-regulatory impairments that take the form of profound and persistent problems with overwhelming emotional distress, identity, alterations in consciousness, loss of relational trust and chronic unexplained health problems (Ford & Fournier, 2007; Ford & Smith, 2008; Roth *et al.*, 1997; Van der Kolk *et al.*, 2005).

The findings of the field trial revealed that the earlier onset and the longer duration of the trauma the more profound the psychological damage, and the more likely the symptoms are to go beyond PTSD (Pelcovitz *et al.*, 2000; Roth *et al.*, 1997; Van der Kolk, 2002; Van der Kolk *et al.*, 2005). Additionally symptoms are more severe with interpersonal trauma (McLean & Gallop, 2003; Van der Kolk, *et al.*, 2005), with the negative effects exponentially increasing for victims of intra-familial abuse (Briere & Runtz, 1988; Hartman, Finn & Lean, 1987; Harter *et al.*, 1988; Herman *et al.*, 1986; Harter, *et al.*, 1988). In turn, it has been found that interpersonal traumas experienced in adulthood, such as captivity as a prisoner

of war or concentration camp detainee, torture and chronic spouse abuse result in more pervasive sequelae than witnessed in those who have been victims of accidents or disasters (Pelcovitz *et al.*, 2000; Roth *et al.*, 1997). Despite the fact that research has repeatedly demonstrated that individuals exposed to chronic maltreatment by their caregivers suffer from more psychological disturbances than individuals who are exposed to accidents or disasters, frequently all trauma-related psychopathology continue to be subsumed under the category of 'PTSD'.

There is little agreement about the relationship between complex PTSD and 'simple' PTSD. In contrast to the DSM-IV field trial which found a 92% comorbidity rate between DESNOS/ complex PTSD and PTSD (Roth *et al.*, 1997), Ford (1999) found that the presence of PTSD is not a prerequisite for DESNOS/ complex PTSD. This led him to propose that although they are comorbid, they are fundamentally distinct conditions. Further research is needed to elucidate these findings. What is clear is that the symptomatology resulting from exposure to chronic interpersonal trauma poses distinct challenges to the diagnostic classification system. Thus clinicians attempting to describe and understand the symptomatology will have to go beyond the diagnostic categories provided by the current classification system.

1.1.3 Definition and Overview of Complex Trauma

Complex trauma is a term used to describe experiences which arise from severe, prolonged and repeated trauma which is often of an interpersonal nature (Van der Kolk *et al.*, (1996). Courtois and Ford (2009) have defined complex psychological trauma as:

"involving stressors that 1) are repetitive or prolonged; 2) involve direct harm and/or neglect and abandonment by caregivers or ostensibly responsible adults; 3) occur at developmentally vulnerable times in the victim's life, such as early childhood; and 4) have great potential to compromise severely a child's development" (p 1).

Complex trauma is a term used to distinguish it from acute trauma which is typically considered to be a one-off or time limited event. Terr (1991) was the first to describe these in terms of type I and type II trauma, with type II often being used interchangeably with the term "complex trauma." Complex/ Type II trauma is associated with the enduring conditions and repetitive events characteristic of interpersonal trauma and victimisation. Herman (1992a) has written eloquently about the ways in which complex trauma alters

basic self-structure, attachment systems, and the individual's connection with larger communities.

The prototype trauma that was first described under the term complex trauma was child abuse (Courtois, 2008), such as childhood physical abuse, childhood sexual abuse (CSA), emotional abuse or neglect (Allen, 2001; Briere, 2006), which have been shown to have an impact on the maturation of the brain (Gerhardt, 2004; Schore, 2001). Complex trauma frequently encompasses situations where an individual is held in a state of captivity, under the control of a perpetrator (Herman, 1992a; 1992b). In addition to child abuse, such conditions are also found in domestic violence, as well as in situations where human rights are violated such as genocide, persecution, torture, political repression, internment within concentration camps, ethnic cleaning, captivity within prisoner of war camps, forced refugee status, relocation through human trafficking, prostitution and other atrocities (Chu, 2011; Courtois, 2008; de Jong *et al.*, 2005). Generally this type of trauma cannot be physically avoided and cognitive avoidance may be the only option available to the victim, for example through dissociation (Kohlenberg *et al.*, 2006).

Reflecting its chronic and frequently developmental aetiology, survivors of complex trauma can develop difficulties with emotion regulation, chronic difficulties in identity, boundary awareness and cognitive distortions about themselves, their value in relationships and the motivations of other people (Herman, 1992; Van de Kolk *et al.*, 2005). These can contribute further to relational difficulties and deficits which have been identified as the legacy of abuse related trauma for some time (Courtois, 1979; Finkelhor, 1990). Some areas of interpersonal functioning that can be affected by repeated traumatic experiences include difficulty trusting others, fear of being abandoned by others, difficulties in affect regulation, lower satisfaction in intimate relationships and higher likelihood of re-victimisation (Beck *et al.*, 2009; Fonagy & Bateman, 2008). In the last twenty years these difficulties in relationships and the ability to connect with others have been given additional emphasis by attachment researchers (Siegal, 1999) drawing on Bowlby's (1988) work. Complex trauma is now accepted as having a contributing role in a range of difficulties and disorders including depression, anxiety, relationship difficulties, PTSD, personality disorders

(particularly borderline personality disorder (BPD))¹ medical and somatic concerns, eating disorders, dissociative disorders, self-harm, psychosis, suicidal behaviours and substance misuse, amongst others (Briere, 2004; Chief Medical Officer, 2008; Herman, 1992; Himber, 1994; Myers *et al.*, 2002; Pribor *et al.*, 1993; Sparto, *et al.*, 2004; Yen *et al.*, 2002).

The impact of complex trauma on an individual cannot be regarded as a simple cause and effect relationship. As is intimated by its name, the trajectories by which complex trauma can exert its effects are multifaceted and convoluted. People respond to adversity in highly individualised ways; for example, who the perpetrator is, the age, and the temperament of the survivor will influence the outcome of complex trauma (WHO, 2002). Additionally children who experience abuse, but who have a relationship with a warm, competent and supportive caregiver generally survive better than those who do not have such a relationship (Cole & Putnam, 1992; Luthar & Zigler, 1991). A crucial factor is the non-abusive parent's reaction to the abuse upon the discovery or disclosure. If a child is supported, their reality is validated and steps are made to protect him or her (Cole & Putnam, 1992; Gold, 1986). The range of impact of complex trauma falls on a wide spectrum, from no negative impacts through mild, transient difficulties to severe, incapacitating difficulties which impact many aspects of life (Ferguson, 2012).

1.1.4 Issues of definitions and terminology

Problems in defining the scope of early traumatic experience are compounded by confused and inconsistent descriptions of what is considered a traumatic event as well as a tendency towards narrow definitions. Experiences of abuse, in particular CSA are frequently considered synonymous with traumatisation (Finkelhor & Brown, 1985), whereas exposure to physical and emotional abuse and neglect has received less focus in this context. The reason for this focus may be because, not only does sexual abuse involve a huge violation of roles and boundaries, but defining sexual abuse may involve fewer ambiguities compared to defining physical or emotional abuse or neglect, thus making it is easier to quantify (Chu, 2011). The privileged position in research that CSA has taken does not imply

¹ Borderline personality disorder overlaps considerably with experience of complex trauma ([Herman, 1992a; Zanarini *et al.*, 1997](#)), to the extent that some experts have proposed that borderline personality disorder be separated from the axis II diagnosis and be subsumed under the construct of complex PTSD ([Herman, 1992; McLean & Gallop, 2003](#)).

that the subsequent effects of other types of maltreatment are less serious. Moreover, researchers have found that it is difficult to differentiate the effects of sexual abuse from the consequences of physical and emotional abuse (Briere & Runtz, 1990) and the dysfunctional family experience with which they frequently co-exist (Alexander & Lupfer, 1987; Harter *et al.*, 1988). Psychological trauma is defined in different ways by different experts Saakavine *et al.*, (2000) emphasise that it is an individual's subjective experience that determines whether an event is or is not traumatic.

It is very challenging to separate and identify the direct effects of one form of maltreatment from another. For a large proportion of children who have been exposed to adverse childhood events, their experiences are multiple and co-occurring (Claussen & Crittenden, 1991; Ney *et al.*, 1994). Only 5 % of maltreatment cases involve a single form of maltreatment, frequently it is a 'tangled web' of abuse and neglect that occurs (Ney *et al.*, 1994). Psychological abuse and a negative family environment are almost always a component of other forms of abuse (Nash *et al.*, 1993). Additionally a substantial and growing literature on re-victimisation suggests that individuals who are abused as children are at substantially increased risk of violent victimisation in adulthood (Messman & Long, 1996; Wyatt *et al.*, 1992). The more types and incidents of abuse a person has suffered and the earlier the abuse begins, the greater the impact and effects on the individual (Chu & Dill, 1990; Dube *et al.*, 2002; Dube *et al.*, 2007; Edwards *et al.*, 2003).

1.2 The role of attachment in complex trauma

It is difficult to consider complex trauma without addressing the quality of the parental attachment bond (Baer & Martinez, 2006; Minzenberg *et al.*, 2006). The investigation into the damaging effects of childhood trauma has led to re-examination of attachment theory- the contributions of Bowlby (1969; 1973; 1980) and others- to understand the effects of early disruptions of parent-child bonding. Attachment theory holds that the interactions between child and parent (or other caregiver) determine specific relational patterns. These patterns are established early in life and endure into adulthood. Certain adult relational patterns may originate from the different attachment styles in children. As caregivers clearly vary in their levels of affection and responsiveness, infants develop various coping strategies for regulating their anxiety and affect associated with whether or not their needs are adequately met (Bowlby, 1969; 1973; 1980).

Bowlby described various attachment styles that were subsequently classified into three categories using Ainsworth's Strange Situation (Ainsworth, Blehar, Waters *et al.*, 1978). These were secure attachment and two forms of insecure attachment- avoidant attachment and ambivalent attachment. An additional category of early insecure attachment, disorganised attachment was introduced by Main & Solomon (1990). When attachment needs are well-met a child develops a sense of having a secure base from which they can explore the environment. A securely attached child comes to see themselves as worthy of other's attention and sees others as trustworthy and responsive (Bowlby, 1969; 1973; 1980). However an insecurely attached child comes to view him or herself as unworthy of other's attention and sees others as unreliable, untrustworthy and perhaps abusive. Children with avoidant attachment styles become highly distressed when the parent is absent. When the parent returns the child may want contact but avoids it. As adults, individuals with this attachment style are distrustful about the intentions of others and minimise the need for attachment and relationships (Ainsworth *et al.*, 1978). Again children with ambivalent attachment styles become distraught when the parent leaves, but on the parent's return they are not easily consoled. In adulthood, individuals with this attachment style can be considered needy, highly emotional and overly dependent and they tend to blame themselves for any relational problems (Bowlby, 1969; 1973; 1980). Disorganised attachment derives from relationships with caregivers which the child experiences as fear-provoking, frequently in situations of psychological, physical or sexual abuse. Children in these situations find themselves in an impossible position, where the caregiver is "*at once the source and the solution*" (Main & Solomon, 1990, p163); that is the child depends on the abusive caregiver for consolation from the abuse itself (Freyd, 1996; Shengold, 1979). A central part of Bowlby's attachment theory (1973) is his concept of the internal working model, which is a mental construction or schema formed on the basis of a child's early experience with an attachment figure. These Internal working models are comparable to schemas about self and others proposed by other theorists (McCann & Pearlman, 1990; Young *et al.*, 2003). Importantly these inner working models are considered to dynamic in nature, with the potential to be updated through the provision of new relational experiences (Kinsler *et al.*, 2009; McLewin & Muller, 2006).

A substantial body of empirical findings challenge the 'trauma per se' view, and suggest that ineffective family environment makes a considerable impact upon the long-term symptoms of child-abuse survivors which exceeds that accounted for by the abuse itself

(Alexander, 1993; Mullen *et al.*, 1993; Widom, 1999). Alexander (1993) examined the differential effects of abuse itself and compared this with the type of family environment in which the abused children was raised. Her results were supportive of a relationship between exposure to CSA and the expression of PTSD symptoms in adulthood. However, her findings also suggest that the characterological types of symptoms frequently witnessed among adult survivors are related to attachment style (which is a function of the family environment as opposed to the abuse) (Alexander, 1993). Much of the distinction between “simple” PTSD and complex PTSD involves the characterological difficulties comprising the criteria of complex trauma. Alexander’s (1993) findings therefore intimate that while PTSD symptoms may be largely attributable to abuse trauma, complex trauma may be a primary consequence of the context surrounding the trauma and the subsequent attachment relationships surrounding the abuse.

The mental representations of attachment are central to the understanding of much psychopathology (Cicchetti *et al.*, 1990; Stroufe, 1995). The concept of internal working models are particularly applicable to the study of early interpersonal trauma in that it could help explain both the long-term interpersonal problems and the disturbances of sense of self so frequently observed in abuse survivors (see Alexander, 1993; Barach, 1991; Gold, 2000). Longitudinal evidence suggests that childhood maltreatment is associated with developing an insecure- disorganised attachment style (Barnett *et al.*, 1999). Additionally, pre-existing insecure attachment status also increases the likelihood that childhood physical or sexual abuse remains unresolved (Stalker & Davies, 1995).

1.2.1 Relational Trauma

Early trauma can be defined by overt life experiences which occur in the context of abusive care-giving, as in ‘complex trauma’. Alternatively, trauma can be considered as something intrinsically relational, as in something that is produced within the patterns of our early relationships (Schore, 2001). Studies examining the quality of early attachment experiences between caregivers and children on neurophysiology and later health and emotional disturbance have found that seriously disrupted attachment is constitutive of trauma in and of itself. Allen (2001), Schore (2003a; 2003b) and others label this form of lack of connection attachment or relational trauma. When a child is left psychologically alone to cope with his or her heightened dysregulated emotional states their immature cognitive system is unequipped to self-regulate affect. They are dependent on a regulating

or containing caregiver without which the child will be left in a chronic state of hyper-arousal which can cause lasting changes at a neuropsychological level (Perry *et al.*, 1995; Schore, 2001). During the early stages of child development it is the non-verbal right brain which is at a critical state of development (Schore, 2001). The right brain is known to be dominant for socio-emotional processing, including the mediation of attachment behaviours (Schore, 2000). There are two important implications of these neuropsychological effects. Firstly, relational trauma is experienced within the body and cannot be laid down in verbal memories. Secondly the individual may be predisposed to vulnerabilities in processing and containing affect, and in negotiating interpersonal relationships (Van der Kolk & Fislir, 1995).

Clearly the concepts of complex trauma, attachment and psychopathology interact in a multitude of complex ways, which are difficult to separate.

1.3 Prevalence of Complex Trauma

Complex trauma is understood to be highly prevalent in our society (Finkelhor, 1994), although measuring its prevalence is very challenging. WHO (2002) has estimated that 20% of women worldwide have been subjected to sexual abuse in childhood. Research investigating prevalence rates of sexual abuse amongst boys has demonstrated lower rates than those seen in girls, but the rates are still high. Using a broad definition of sexual abuse, referring to unwanted sexual contact in childhood, research has found that one in six or seven men in the general population report some kind of abuse (Briere & Elliot, 2003; Finkelhor *et al.*, 1990). The few studies that have been conducted to examine rates of childhood physical abuse have suggested rates of 20-30% for both girls and boys (Briere & Elliot, 2003; Mendal, 1995). The Scottish government accepts the estimate that 1 in 5 women will experience domestic abuse across their lifetime². Research has suggested that amongst women who have experienced domestic violence 70-80% have also survived physical and/or sexual abuse in childhood (Owens-Manley, 1999). For individuals in mental health services, prevalence of exposure to complex trauma is considered much higher than in the general population. It has been estimated that in excess of 70% of women (and a significant number of men) using NHS mental health services have a history of violence and abuse including childhood abuse, childhood neglect or domestic abuse in adulthood (NHS

² (<http://www.scotland.gov.uk/Topics/People/Equality/violence-women/Key-Facts>)

Confederation briefing paper June 2008). It has also been demonstrated that mental health patients are much more commonly the victims of chronic, intra-family and multiple types of abuse (Bryer *et al.*, 1987; Chu & Dill, 1990; Chu, Frey *et al.*, 1999; Sax *et al.*, 1993). Complex trauma is also found to be particularly prevalent in some vulnerable populations which include those who are involved with substance misuse services (Loukes, 1998; Harris & Fallot, 2001).

1.3.1 Policy and strategic framework.

The experience of child abuse is increasingly acknowledged to be a public health concern (e.g. Edward *et al.*, 2003; Sparto *et al.*, 2004; Annual Report of the Chief Medical Officer, 2008). Research conducted in the United States during a 1-year window (Macy & Van der Kolk, 1999), found that individuals in the mental health system with histories of chronic childhood trauma had more frequent hospital admissions and were more expensive to treat than any other psychiatric patient group (Van der Kolk, 2009). The magnitude of the problem is beginning to be recognised. In 2005 the Scottish Government launched the Survivor Scotland initiative³ which set out a strategy to develop services for survivors of childhood abuse. The aim of this was to develop training for workers, to ensure greater priority and joined-up working across national and local mainstream services, and to generally improve the lives of individuals who have suffered childhood abuse (Survivor Scotland, 2005). The Gender Based Violence (GBV) strategy for NHS Scotland set out in CEL_41 (2008) recognises the need to provide suitable trauma-informed systems and services. In trauma informed services trauma is viewed not as a discrete event, but rather as a defining principle and organising experience that shapes the core of an individual's sense of self and others (Harris & Fallot, 2001). In a trauma-informed system, practitioners assume that when an individual has experienced trauma the fundamental laws of life have been changed. An individual's meaning system is likely to have been constructed around the trauma, which then informs other life choices, and can lead to the development of certain coping strategies (for example substance misuse) (Finkelstein *et al.*, 2004; Harris & Fallot, 2001). Trauma-informed services incorporate early traumatic experiences in the conceptualisation of the survivor's difficulties. Traumatic experiences are not inevitably the focal point of referral and treatment in trauma-informed services, however, by using this

³ (www.survivorscotland.org.uk)

approach, services can be designed to help enable survivors to feel more empowered and reduce potential experiences of power-imbalance or perceived rejection (Harris & Fallot, 2001).

Trauma specific services explicitly set up to provide a specialist clinical intervention to survivors of trauma using models and treatments based on trauma theory (Harris & Fallot, 2001). The Matrix (NHS Education Scotland, 2011) outlines all of the evidence based treatments for psychological interventions, and for the first time includes complex trauma. This has provided an impetus for NHS boards to consider formally the range of psychological interventions survivors of complex trauma may benefit from (<http://www.nex.scot.nhs.uk/education-and-training/by-discipline/psychology/matrix.aspx>).

Addressing trauma in substance misuse treatment involves both trauma-informed and trauma-specific approaches. Harris and Fallot (2001) emphasise how providers of substance misuse services need to recognise the multiple complex interactions between substance misuse and trauma. Government documents such as 'Commitment 13' (Mental Health in Scotland: Closing the Gaps- Making a Difference, 2007) and 'Essential Care' (Scottish Government, 2008) highlight the need for substance misuse agencies to pursue sensitive ways to include a history of childhood trauma history in an individual's assessments, and for professionals in these services to be skilled in the delivery of an individual's disclosure of trauma and abuse, as well as being able to manage it appropriately and provide suitable psychological interventions.

1.4 The prevalence of exposure to early interpersonal trauma in substance misuse populations

Due to the fact that childhood abuse has been identified as the prototypical type of trauma considered to be a form of complex trauma (Courtois, 2008; Herman 1992), the prevalence of this type of complex trauma amongst individuals presenting for substance misuse treatment will now be examined. Studies of women in substance misuse treatment suggest that from 30 per cent to more than 90 per cent of them have experienced physical or sexual abuse (or both) depending upon the definition of abuse and the specific target population (Grice et al., 1995; Fullilove *et al.*, 1993; Navajatis *et al.*, 1997). Many

researchers have noted that women with histories of sexual and physical abuse are at risk of substance misuse (Diamond, 2000; Harris, 1994; Miller, 1990, 1994, 1996; Zlotnick *et al.*, 1997). The picture does not look that different for men, Stein *et al* (1988) report that men with histories of childhood abuse are significantly more likely than their non-abused counterparts to develop a substance misuse problem. There is a high prevalence of a history of childhood neglect in substance misusing populations (Evans & Sullivan, 1995). In research involving almost 10,000 patients in a medical setting (Felitti *et al.*, 1998), the Adverse Childhood Experiences Study (ACE) demonstrated a highly significant relationship between adverse childhood experiences and later substance misuse, those with histories of being severely maltreated as children showed a 4 to 12 times greater risk of developing alcoholism and drug abuse than those who were not maltreated (Felletti *et al.*, 1998).

Studies vary sizeably with respect to their definitions of maltreatment, sample size, data collection, differing populations observed and methodological rigor. The majority of studies are retrospective in nature, which can bring about recall biases; particularly as both trauma and substance misuse can have disruptive effects on memory (Najavits, *et al.*, 1997). Despite the methodological difficulties inherent in studying the relationship between childhood maltreatment and later substance misuse, a great deal of empirical research has been conducted examining this issue. The relative homogeneity of findings across studies that vary so widely in samples and methodology is evident. Harris and Falloot (2001) emphasise that the very fact that the correlation between child abuse and later substance misuse appears to exist must be incorporated into any substance misuse recovery program.

1.4.1 Complex Trauma and Substance Misuse

Svanberg *et al.*, (2011) conducted an audit to examine the types of cases that present to the Greater Glasgow and Clyde substance misuse psychology team. Patients were assessed and comorbidity investigated, their results indicate that the most common presenting mental health problem co-occurring with substance misuse was a history of complex trauma/ type II trauma, which was present in 66 per cent of patients assessed. The second most prevalent psychological problem was PTSD/ type I trauma present in 9 per cent of presenting patients (Svanberg *et al.*, 2011). Therefore a total 75 per cent of clients included in this audit were affected by difficulties relating to exposure to psychological trauma with the majority reported symptoms consistent with complex/ type II trauma. The patients with a history of complex trauma/ type II typically presented with multiple difficulties on the

background of repetitive and prolonged traumatic experiences. These included traumatic events in childhood and adulthood (such as sexual, physical and emotional abuse and neglect) and resulted in difficulties in affect regulation, self-perception, relationships, systems of meaning, and somatisation. Despite being based on a small sample size Svanberg *et al's.*, (2011) audit exemplifies the high levels of co-occurring complex trauma present in substance misusing patients seeking psychological treatment. However, the role of complex /type II trauma in substance misuse and how it affects substance misuse treatment continues to be predominately unstudied (Ford & Smith, 2008).

Ford *et al.*, (2007) conducted research to examine to what extent PTSD and/or complex PTSD symptoms effect outcome in an outpatient contingency management treatment for substance misuse. Ninety-five per cent of the substance misusers in this study reported a history of trauma exposure to a minimum of one out of a possible ten types of psychological trauma (93% starting before they were aged eighteen). Despite using brief measures for determining PTSD and complex PTSD symptoms, Ford *et al.*, (2007) found that of those participants exposed to trauma approximately 49% were determined to have PTSD and 51% complex PTSD. The results showed that the most robust correlates with treatment outcomes were complex PTSD symptoms, which were inversely related to treatment retention and abstinence during treatment. Although PTSD and complex PTSD symptoms were interconnected, it was solely complex PTSD symptoms that predicted worse treatment outcome. This is consistent with Ford and Kidd's (1998) findings that complex PTSD, rather than PTSD predicted disadvantageous outcomes in PTSD treatment.

Ford & Smith (2008) conducted research to examine similarities and differences in the precursors and correlates of PTSD and complex PTSD in a substance misuse sample. They looked at substance misusers who had been exposed to trauma and found that 45 per cent of them had complex PTSD. Similar to the field trial for psychiatric patients (Van der Kolk, *et al.*, 1996; Roth *et al.*, 1997), they found that in the majority of cases (over 90%) complex PTSD occurs in combination with PTSD (Van der Kolk *et al.*, 1996; Zlotnick *et al.*, 1997; Feletti *et al.*, 1998; Ford, 1999; Mclean & Gallop, 2003). Additionally, consistent with research suggesting that re-traumatisation or cumulative trauma is linked with increasingly severe impairment (Banyard *et al.*, 2001), the addition of sexual trauma in adulthood to a history of childhood sexual abuse further increases the likelihood of comorbid complex PTSD (compared to the presence of PTSD alone). Drawing on their findings Ford & Smith

(2008) propose that the PTSD diagnosis alone may not be adequate to characterise the difficulties encountered by many substance misusing clients. They go on to suggest that although complex PTSD does not currently comprise a separate diagnosis from PTSD, acknowledgement and understanding of its impairments in emotional, cognitive and somatic self-regulation may increase clinicians working in the field of substance misuse abilities to assess and treat these patients effectively (Ford & Smith, 2008).

Previous research has held that comorbid substance misuse and PTSD tends to occur after severe trauma exposure and may comprise particularly severe PTSD symptoms (Riggs *et al.*, 2003; Saladin *et al.*, 1995). It is worth noting however that these studies have not distinguished between PTSD and complex PTSD symptoms. Therefore the documented frequency of substance misuse and PTSD, as well as the tendency of PTSD and substance misuse to exacerbate and sustain each other over time (Saladin *et al.*, 1995) may be due, (at least in part) to complex PTSD symptoms. Complex PTSD symptoms have been demonstrated to be more strongly correlated with severe re-experiencing symptoms than PTSD alone (Ford, 1999), which has been found to be associated with elicit substance misuse as individuals attempt to self-medicate their post-traumatic distress (Stewart & Conrad, 2003). Higher levels of substance misuse have been found to be associated with dissociation (Seedat, *et al.*, 2005), which in turn is associated with more severe and earlier trauma (Liotti, 2004). Research is required to establish the extent to which impairment that has previously (and in some cases continues to be) ascribed to PTSD co-occurring with substance misuse, may actually be due to complex PTSD symptoms. Although this process is likely to be challenging and would involve a re-examination of strict exclusion criteria, it is likely it would lead to improvement in treatment for this population.

1.4.2 Interrelation between substance misuse and complex trauma

The exact nature of the connections between trauma and substance misuse is not well understood, there are multiple, complex interactions between substance misuse and complex trauma. These may date back to the time the trauma occurred, for example frequently perpetrators of abuse are drug or alcohol dependent (Bays, 1990; Rose *et al.*, 1991), are under the influence of substances at the time of the abuse (Coleman, 1987; Finkelstein, 1996), or may have induced children to ingest substance before they abuse them (Finkelstein *et al.*, 2004). Many survivors of childhood trauma have used substances (often from an early age and over the course of treatment) either to cope with or suppress

or avoid trauma associations (Conrad & Stewart, 2003). Substance misuse might also be implicated in the suppression of, or loss and subsequent recovery of an individual's memory for past trauma (Courtois, 2010). The relationship between substance misuse and trauma has been accounted for by three prominent theoretical models, the self-medication, the high-risk and the susceptibility hypotheses (Brady *et al.*, 2004).

Khantzian's self-medication hypothesis (1985, 1997) holds that substance misuse occurs in a context of difficulties with self-regulation, particularly difficulties with self-esteem, regulation of emotions, relationships and self-care. Potential substance misusers suffer as a result of their feelings, either being severely overwhelmed with distressing emotions or seeming to not feel any emotions at all. This model suggests that substances may be used in an effort to lessen or numb overwhelming emotions that are confusing, painful or threatening. Substances have specific psychopharmacologic effects and individual's frequently develop a preference for particular substance (s) based on the particular effects it produced (Khantzian, 1997). This model suggests that the traumatic event and trauma-related symptoms would precede the development of substance misuse difficulties, although Khantzian (1997) notes that after time the individual, the pain, and the substance form an interactive triad.

The high-risk hypothesis proposes that substance misuse is part of a wider group of high risk behaviours which increase the risk of exposure to potentially traumatic events and therefore increase the risk of developing trauma-related symptomatology (Johnson *et al.*, 2006;). Johnson *et al.*, (2006) studied the temporal associations between exposure to traumatic events and substance misuse onset. They recruited a sample of injecting drug users (n=1098). Their results supported the high-risk hypothesis that showed that onset of substance misuse began prior to the traumatic event.

The susceptibility hypothesis proposes that substance misuse may affect an individual's physiological functioning in such a way that they are more susceptible to developing trauma-related psychopathology after experiencing a traumatic incident than others in the general population (Kingston & Raghavan, 2009). The high-risk and susceptibility hypotheses suggest that the substance misuse problem precedes the exposure to trauma and trauma-related symptoms.

The self-medication hypothesis has received the most research support (Chilcoat & Breslau, 1998a; 1998b; Dansky *et al.*, 1995). However some have criticised it for being too simple and not taking into consideration biological research which has explored the mechanisms of reward, motivation to misuse substances, and the impact on mood of chronic, excessive drug use (Goldsmith, 1993). In reality it is improbable that a unidirectional pathway between substance misuse and exposure to trauma exists. Rather it is likely that a complex interrelationship exists in which the symptoms of one of the difficulties maintain the symptoms of another (Fullilove *et al.*, 1993; Steward & Conrod, 2003).

Another theory which has not been widely discussed as part of the trauma/substance misuse debate but which may be of relevance to this discussion is the '*addiction as an attachment disorder*' argument put forward by (Flores, 2003, p6). Flores (2003) holds that substance misuse treatment specialists familiar with attachment theory (Bowlby, 1979) and self-psychology (Kohut & Wolfe, 1978) acknowledge that an inverse relationship exists between addiction and healthy interpersonal attachment. He goes on to propose that substance misusers insecure attachment styles (which frequently develop as a consequence of trauma) interfere with their ability to gain satisfaction from interpersonal relationships and contribute to internal working models that perpetuate these difficulties. This in turn leaves certain individuals with vulnerabilities which increase substance misuse behaviours, which are in fact misguided attempts at self-repair (Flores, 2003). In fact individuals with insecure/disorganised attachments can find substance misuse particularly attractive because they can trust their substances more than they can trust human beings (Carruth & Burke, 2006). In accordance with this perspective Nakken (1996) writes that addiction is '*an emotional relationship through which addicts try to meet their needs for intimacy*' (p8). Substance misuse, because of its effects and the lifestyle attached to it, further exacerbates difficulties with attachment relationships. Thus from an attachment theory perspective substance abuse is both a solution and a consequence of the person's difficulty in developing healthy attachments. Substance misuse treatment from an attachment theory holds one basic principle: until substance misusers develop the capacity to establish mutually fulfilling relationships, they remain vulnerable to relapse and addiction. Thus to succeed in treatment, the individual must learn how to establish healthy relationships (Flores, 2003).

1.5. Treatment implications

The presence of a co-morbidity of substance misuse and a history of trauma can add additional treatment challenges. The presentation and symptoms of these individuals tend to be more severe than those of patients suffering from either disorder alone (Ford *et al.*, 2007; Ouimette, Moos & Finney; 1999). They are more resistant to treatment and outcomes of treatment are generally worse for them than for individuals with other co-occurring difficulties, and for patients with substance misuse alone (Ouimette *et al.*, 1998; Ouimette *et al.*, 1999), they tend to be significantly younger at the age of onset of substance misuse (Brems & Namyniuk, 2002) - and to use the most potent drugs (cocaine and opioids) (Najavits *et al.*, 1997). Complex PTSD has also been found to interfere with the ability to inhibit substance cravings and relapse-prevention behaviours (Allen *et al.*, 1998; Ford *et al.*, 2006). When individuals presenting to substance misuse services with trauma histories are not adequately accommodated for, it can hamper their engagement in treatment, lead to early drop out and make relapse more likely. (Amaro *et al.*, 2007; Brown, 2000). Although treatment can be effective (Najavits, 2002a), it is often difficult and marked by volatile therapeutic relationships, numerous crises, inconsistent attendance, and relapse to substance misuse (Brady *et al.*, 1994; Brown *et al.*, 1996; Triffelman *et al.*, 1995).

Considering the difficulties facing clinicians whose work involves the treatment of individuals with substance misuse issues and a history of complex trauma, it would seem that a literature providing clear treatment guidance could be particularly beneficial. However the literature reflects wide-ranging, and at times contradictory opinions including narrow conceptualisations concerning what is considered traumatic symptomatology (Herman, 1992; Van der Kolk, 2005), as well as a diversity of opinions regarding how to address co-occurring substance misuse and complex trauma issues (Dass-Brailsford & Myrick, 2010; Flores, 2003; Najavits, 2002a). Moreover treatment guidelines in publications such as the NICE guidelines (2007) and The Matrix (NES 2011) tend to offer recommendations that do not adequately accommodate for the high comorbidity of substance misuse and trauma, this being particularly true with respect to co-occurring substance misuse and a history of complex trauma.

1.5.1 Integrated treatments for trauma and substance misuse.

Historically substance misuse and co-occurring trauma-related psychopathology have been tackled separately in treatment regimens (Dass-Brailsford & Myrick, 2010). This has been done using one of two treatment models: i) the parallel model that applies services for

substance misuse and trauma generally with different treatment providers and in different settings and ii) the sequential approach which holds that substance misuse problems must be addressed before trauma related difficulties (Bollerud, 1990; Dass-Brailsford & Myrick, 2010). The NICE guidelines recommend the sequential approach. (It is worth noting that these guidelines relate to simple cases of PTSD, the guidelines for the management clients who have been exposed to complex trauma have not yet been published (NICE 2005)). Both of these approaches, however, can be criticised for underestimating the extent to which trauma symptoms and substance misuse are closely interconnected (Finkelstein *et al.*, 2004).

Beyond the lack of coordination that frequently exists in the parallel approach, it perpetuates the notion that difficulties and parts of the self can be compartmentalised and dealt with separately. This may run the risk of replicating the compartmentalisation that may already exist for survivors of complex trauma, who have frequently used techniques such as dissociation to separate parts of themselves from others, as an attempt to cope with their abuse (Harris & Fallot, 2001; Herman, 1992a). The sequential approach presents a treatment paradox, namely how can a substance misuser give up the substance misuse behaviours in order to address the underlying complex trauma issues, if it is the trauma-related psychopathology that is creating the need to use substances (Miller & Guidry, 2001). It can also be criticised for holding an inherent assumption that substance misuse problem is the primary disorder, which is often in fact not the case (Harris & Fallot, 2001).

In light of these difficulties integrated treatments, where trauma and the substance misuse are addressed simultaneously, have frequently now been considered best practice (Evans & Sullivan, 1995; Harris & Fallot, 2001). Integrated treatments address the needs of the whole person and are based on the assumption that the trauma and substance misuse problems interact in a complex way, and often form mutually reinforcing relationships within the life and being of an individual (Finkelstein *et al.*, 2004). Many clinicians and researchers hold that integrated treatments are more likely to be successful, to be cost effective and are more sensitive to client's needs (Abueg & Fairbank, 1991; Brady *et al.*, 1994; Brown *et al.*, 1999; Evans & Sullivan, 1995; Kofeod *et al.*, 1998). The integrated approach is consistent with trauma-informed services. However, the efficacy of integrated treatment for substance misusers with trauma-related problems is still relatively unknown.

1.5.2 Trauma-focused treatments and complex trauma.

Trauma treatment outcome research has concentrated almost exclusively on PTSD symptomatology. Many researchers and clinicians hold that there are serious questions about whether the existing treatments for 'simple' PTSD (generally short-term trauma-focused cognitive-behavioural therapy (CBT)) represent effective treatments for individuals with histories of complex interpersonal traumas (Chu, 2011; Courtois, 1999; 2008; Ford *et al.*, 2005; Gold, 2000). Unlike PTSD treatment, there have been no similar successful studies of the use of confrontation of traumatic experiences in survivors of extensive childhood trauma abuse.

Authors such as Alexander (1992; 1993) and Gold (2000) highlight that the interpersonal/family contexts in which the survivors of childhood abuse have developed have not provided them with the adequate resources for secure attachment, emotional regulation or the procurement of adaptive living skills. Thus, survivors of childhood trauma may have lasting deficits that not only affect their current levels of functioning, but also their capacity to cope reliving their traumatic memories in therapy (Gold, 2000; Gold & Brown, 2011). In fact many authors hold that there is a substantial risk that techniques emphasising recovering and exploring traumatic memories implemented in therapy before individual's skills to cope with these highly emotive memories have been developed may exacerbate, rather than resolve distress and dysfunction, and could potentially lead to marked deterioration in individuals who have a complex trauma history (Gold & Brown, 1997; Chu, 2011; Courtois, 1999; 2008).

The use of trauma-focused therapy when substance misuse is part of the presentation is also often cautioned due mainly to the concern that treating trauma related symptoms early in substance misuse treatment may increase the risk of relapse to substance misuse, as was the case in studies conducted by Pitman *et al.* (1991) and Triffelman *et al.*, (1999). Furthermore, it has been particularly difficult for patients who have experienced trauma to maintain abstinence within traditional treatment, especially if they have more intrusive trauma-related symptoms when they stop misusing substances (Ruzek *et al.*, 1998; Solomon *et al.*, 1992).

Additionally, many forms of trauma-treatment (with the exception of models developed by Cloitre *et al.*, (2002), Ford & Russo, 2006; Harris & The Community Connections Trauma Work Group (1998), Linehan (1993), Miller & Guidry (2001), Najavits (2002b) focus exclusively on treating PTSD symptoms, and not on the difficulties in identity, interpersonal

functioning and relatedness that are so common amongst individuals who have experienced complex trauma (Briere & Scott, 2006). For example research involving women with comorbid substance misuse and PTSD with a history of complex trauma found that CBT reduced the PTSD symptoms (Cohen & Hien, 2006); however, there were no significant differences in other symptoms associated with the sequelae of complex trauma, namely depression, dissociation and social and sexual functioning. These findings as well as others (Alexander, 1992; 1993) indicate that a focus on the abuse in and of itself is not the solution to resolving the relational problems and dysfunction commonly observed in survivors of complex trauma.

1.5.3 Lack of empirical evidence or formal guidelines

One of the difficulties for treatment of complex trauma sequelae is that there is no single psychological model which offers an understanding of the impact of complex trauma on mental health. In addition, the formalised research base on treatment efficacy and outcome is very slim for individuals with a history of complex trauma. The lack of relevant research findings and clear guidelines has meant that expert opinion and consensus have had to be drawn on to guide treatment. Svanberg *et al.*, (2011) highlight the difficulties of working with the complexities that arise when individuals have comorbid substance misuse with histories of complex trauma and the need to draw on theoretical perspectives beyond the two main models promoted in substance misuse services of CBT and Motivational Interviewing. Many clinicians working with individuals who have complex trauma histories use treatment models that are not supported by empirical research, but instead are based on accumulated clinical experience (Ford *et al.*, 2005; Herman 1992a).

1.5.4 The phase-based approach

Over the last twenty years a standard of care for survivors of complex trauma has evolved which indicates a multi-phasic and multi-modal treatment approach. This approach is divided into three main stages or phases of treatment which are organised to address specific clinical issues sequentially. This approach is holistic, comprehensive, and biopsychosocial and is supported by several clinician-investigators (Chu, 2011; Courtois *et al.*, 2009; Herman, 1992; Steele *et al.*, 2005), and the Matrix, (2011)⁴. This approach

⁴ One may assume that you can only apply a trauma treatment model with clients who have been officially diagnosed with complex PTSD/PTSD however many experts in the field stress that a history of severe child abuse or neglect is sufficient

provides a useful framework for interventions which can otherwise reflect a clinician's training and preferred treatment approach (within the available evidence base):- for example cognitive-behavioural, existential, psychodynamic or humanistic treatment approaches.

The initial stage of treatment is devoted to establishing personal safety, teaching skills and strategies to enable emotion regulation, and emphasising the therapeutic relationship as a place of security and support where emotions can be named and understood (Herman, 1992; Pearlman & Courtois, 2005). A lack of sufficient attention being paid to an individual's safety or ability to regulate strong affect in this first stage may have untoward effects such as increasing acute symptomatology and difficulties with functioning and coping, and re-traumatisation, or for these clients to drop out of treatment studies (Chu, 2001; Courtois, 2008; Gold & Brown, 1991; (McDonagh-Coyle *et al.*, 2005). After the goals of symptom reduction and stabilisation are reached and an individual has learnt how to regulate their own affect and avoid re-traumatisation (Pearlman & Courtois, 2005), the second stage concentrates on confronting, working through, and integrating traumatic memories. The final stage focuses on life integration, rehabilitation, personal growth and reconnection (Ford & Russo, 2006). Herman's Phase intervention model named the three phases Safety, Remembrance and Mourning and Reconnection. In Chu's (1992) treatment model for complex PTSD they are named Early, Middle and Late. The partition of the course of treatment is somewhat arbitrary, because individuals generally move back and forwards between phases, rather than progressing in a neat linear fashion (Chu, 1992; 2011; Herman, 1992a; Steele *et al.*, 2005). However, this demarcation is considered useful in specifying the components and sequence of treatment (Chu, 2011).

In substance misuse treatment, stage/phase models are also commonly used (Najavits & Weiss, 1994) and parallel those in complex trauma treatment. The understanding that an individual needs to be stable and attain abstinence prior to more in depth 'character reorganisation' ensues has long been understood by professionals (Brown, 1985; Carroll *et al.*, 1991; Kaufman & Reoux, 1988; Najavits, 2002a) and exemplified by the structure of the twelve steps in Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) (Nace, 1988). The later stage of 'Mourning' (to use Herman's terms) is summarised by Daley, Moss &

grounds for using a trauma treatment model, even if the client does not have a formal diagnosis of complex PTSD (Courtois, 1999; Saakvitne *et al.*, 2000).

Campbell (1993) as the working through of past wrongs and grief that is essential for long term recovery. The Seeking Safety model (Najavits, 2002b) is a dual-diagnosis approach which incorporates many of the Safety (Herman, 1992a)/ Early (Chu, 1992) phase of treatment. It is one of the main models used with dual diagnosis but it only goes to stage 1 of the phased-based approach does not go into trauma re-processing. In fact descriptions of recovery within complex trauma and substance misuse fields are remarkably similar in distinguishing the first stage of treatment as the establishment of safety (Najavits, 2002a).

1.5.5 The resolution of relational issues

The resolution of relational issues is a central component of most phase-oriented models of trauma treatment (see Courtois *et al.*, 2009; Herman, 1992b; Lebowitz *et al.*, 1993; Steele *et al.*, 2001). Chu (2011) highlights how negotiating relationships with survivors of early abuse is undoubtedly the most challenging aspect of the therapeutic work and is usually the most time-consuming aspect of treatment. A number of models of psychotherapy for the treatment of trauma-related disorders explicitly give attention to disordered attachment as a fundamental feature of the treatment process. Gold's (2000) model of Contextual Therapy emphasises the influence of the family and social contexts that surround child abuse. It is based on the assumption that individuals who have been exposed to complex trauma in the form of long-term child abuse often grow up in family environments that failed to teach them many of the fundamental daily living-skills required for effective adult functioning, and that this, as much as discrete incidents of child abuse to which they have been subjected, is the source of many of their difficulties. It moves away from an abuse-trauma orientation to one that is more encompassing and provides a theoretical and treatment framework for working with adult survivors of prolonged child abuse and the multitude of difficulties they can bring to treatment. The model focuses on building collaboration (particularly in the therapeutic relationship), correcting damaging beliefs about the self (especially in relation to perceptions of being undeserving and incapable of maintaining relationships), learning problem-solving and coping skills, and developing and improving interpersonal connections (Gold, 2000). In three complex case studies Gold *et al.*, (2001) describe how surprisingly rapid improvement was attained by focusing on building relational capacities, which then aided the resolution of posttraumatic and dissociative symptoms.

1.5.6 The relational approach

Towards the end of the late twentieth century therapists started to seek a wider understanding of the therapeutic relationship (Paul & Pelham, 2000). The concept of 'relational' emerged in therapy literature in 1980s and since then has progressively developed as an element of existing forms of therapy (Cornell & Hargaden, 2005; Mearns & Cooper, 2005) or a form of therapy in itself (DeYoung, 2003; Paul & Pelham, 2000). The central principle of the relational approach is that *'it is through relationships that we become and maintain who we are, and it is through the therapeutic relationship that personal change can take place'* (Pelham, 2008, p 104). There are many different traditions that have contributed to the notion of the relational approach and relational therapy, discussion of these is out of the scope of this study. However many clinicians in the field of complex trauma propose using a relational framework in trauma-related work (Courtois, 1999; 2010; Pearlman & Saakvitne, 1995; Saakvitne *et al.*, 2000). Pearlman & Courtois (2005) highlight their support for a relational framework for treatment for individuals who have experienced complex trauma, and propose that it is within the therapeutic relationship that the self and attachment difficulties which are at the heart of chronic and pervasive childhood trauma must be understood and addressed.

1.6. Summary and rationale

To date there is dearth of previous research regarding the perceptions and experiences of survivors of complex trauma and the professionals working with them. The limited findings in this area can be summarised as follows. The main positive perspectives about and experiences of talking therapy focused on the development of an equal, open, trusting and non-judgemental therapeutic relationship where clients felt safe to disclose (Chouliaria *et al.*, 2001; McGregor *et al.*, 2006; Phillips & Daniluk, 2004). Survivors of complex trauma also emphasised how important they felt it was the health-professionals they were working with had knowledge and awareness about complex trauma specific issues (Schachter *et al.*, 2004). Negative experiences of therapy for clients with complex trauma histories were therapists taking a sexual interest in them and therapist being passive or unresponsive (Koehn, 2007; Nelson, 2009). The author has found no previous research investigating the experiences or perspectives of professionals working with co-occurring substance misuse and complex trauma. However, research examining this comorbid population suggests that

frequent dilemmas and challenges in this work focus around issues relating to therapist processes that can emerge in the context of the therapeutic relationship (Navajatis, 2002b).

In spite of recent recognition of the high proportions of complex trauma in the histories of substance misuse populations, as well acknowledgment of the lack of adequate theory, evidence base or guidelines concerning how best to address this issues, currently the approaches used to treat this comorbid epidemic are inadequate. Frequently substance misuse services focus predominately on the substance misuse issues, despite the complex trauma symptoms acting as a maintaining factor in the individual's substance misuse difficulties. Additionally, trauma-specific services commonly exclude patients with substance misuse problems. Generally this leads to a disjointed approach to the treatment of this comorbid client group where the complexities of clients' difficulties are overlooked and not adequately addressed within services. The author hypothesised that this could also offer one explanation for the revolving-door phenomena (Najavits, 2006), which is frequently identified as part of the treatment trajectory for substance misuse clients. In accordance with the recent recognition of the imperative need for trauma-informed substance misuse services (Reickmann & Bryan, 2011). This research aims to explore psychologist's perceptions and experiences of working with substance misusers with histories of complex trauma within the context of NHS substance misuse services. The findings from this study will help to increase understanding about what factors contribute to effective therapy, as well as the potential treatment challenges, that may arise in psychological work with this comorbid client group. It is hoped that this will contribute to the development of shared understandings and meanings which can in turn be used to build a professional body of knowledge about, as well as enhance service provision, for this vulnerable and frequently overlooked population.

2 Methodology

2.1 Design

2.1.1 Qualitative approaches

The use of qualitative methodology can be difficult to justify in the existing climate of evidence-based practice in health research. What is frequently claimed as 'evidence' are Randomised Controlled Trials (RCTs) - currently the gold standard in health care research (SIGN, 1999). The presentation of 'evidence' frequently refers to numerical results which aim to attain a clear answer by means of the presence or absence of statistical significance. Within many areas of healthcare provision it may be relatively straightforward to keep conditions equivalent and controlled. However, in work with more complex phenomena it may be very challenging, and in many cases not actually possible (Van Meijel *et al.*, 2004).

Quantitative research is a good way to break up phenomena in order that they become manageable and discrete elements, however, it does not always support the understandings of multifaceted, dynamic phenomena for which qualitative methods are required. If research is only focused upon what we already know how to quantify or what can be dependably quantified, then facts significant in explaining important relationships and realities may be missed (Sofaer, 1999). In a meta-evaluation of substance misuse prevention programmes Schaps *et al.*, (1981) examined 127 studies of interventions to determine the quality of the evaluation methods used and variations in the outcome across categories of intervention. Despite this being a large outcome study in a considerable subset of studies, a lack of data was available on the nature of the intervention. Those studies provided outcome data, but very little process data. In many cases it was, therefore, unfeasible to determine exactly what intervention was being evaluated. In contrast, the 'descriptive' capacity of qualitative methods can provide a more complete articulation of the intervention, a deeper understanding of the sometimes complex processes that underlie numerical findings and can explore and illuminate the 'why' in processes and phenomena (Grypdonk, 2006).

Qualitative research can in some cases become too narrow to be clinically useful; there can be too much emphasis on individual responses making it difficult to generalise findings. When this is the case quantitative research is vital to examine which factors brought up by participants can make a difference. This highlights the important need for a combination of approaches to research within healthcare.

2.1.2 The use of qualitative methods in the current study

The type of methods used in research should reflect the nature of the question being asked (Remenyi & Williams, 1996). Sofaer's (1999) conceptualises research as:

'The process of reducing our uncertainty about important phenomena or questions' (p1103).

She advocates that the development of knowledge involves the continuing reduction of uncertainty, and goes on to highlight how frequently there is uncertainty not only about answers, but also about what the right questions might be, and how they might be constructed to arrive at meaningful answers (Sofaer, 1999). To the author's knowledge there have not been any other studies to date looking at the experiences of psychologists working with substance misusers that have histories of complex trauma, making the concept of reducing uncertainty pertinent. The current study was an explorative investigation without clear expected outcomes, meaning that a qualitative approach was more suitable. In addition, as the study was concerned with the experiences and attached meaning for individual psychologists it was best answered via open ended, participant driven responses.

Quantitative studies tend to hold positivist positions in that they aim to discover truths, patterns or certainties about the world. It was not anticipated that the current research would result in factual outcomes per se, but rather reveal the subjective opinion of those with the lived experience of the topic. This aligns itself with the interpretivist philosophy of qualitative research which conceives that 'truth' is not absolute but relative to the individual and their social surrounding (King & Horrocks, 2010).

2.1.3 Types of qualitative methodology

There are a number of different types of qualitative methodologies available to the contemporary researcher. Typically those applied in health-based research are phenomenological methods, discourse analysis, and grounded theory (Starks & Trinidad, 2007). Although these types of methodology may look alike in process - in that they all use semi-structured interviews, line-by-line analysis and production of higher order and lower order themes- they originate from very different theoretical positions and their aims, therefore, differ significantly (King & Horrocks, 2010).

Discourse analysis examines the use of language and narrative in the construction of meaning; it does offer tangible answers, but instead facilitates access to ontological and epistemological assumptions (Gee, 2005). Grounded theory aims to discover theory from data that has been systematically acquired from social research (Glaser, 1992); it involves theoretical sampling which involves recruiting participants with varying experiences of the same phenomenon (Starks & Trinidad, 2004). Phenomenological analysis seeks to emphasise participant's experience of certain phenomena; in phenomenology the analyst seeks to capture the meaning and common features of an experience (Starks & Trinidad, 2004).

A phenomenological approach was considered the most suitable for the current study as the main aim was to explore and provide clarity concerning the perspectives of the participants. Thus this approach aimed to explore participants' perceived reality, giving voice to their experiences as experts on this topic. The very limited information on the experiences of delivering psychological therapy to substance misusers with histories of complex trauma meant that building an understanding of both individual and shared perspectives was paramount, and needed to take precedence over theory building at this time. Phenomenological analysis encourages a smaller number of transcripts to be analysed in more detail (Smith *et al.*, 2009), thus is most suited the constraints of the current study. There were a number of limitations to the study in terms of time and scope, and it was therefore necessary to be practical and realistic with respect to sampling. There are few substance misuse psychologists across Scotland therefore the pool of potential participants was relatively small to start with.

There are a number of existing phenomenological methodologies including descriptive, empirical, heuristic, life-world and hermeneutics (Werz, 2005). Interpretative Phenomenological Analysis (IPA) is a relatively newly developed theory; it differs from most other qualitative approaches in the value it places on the ideography in which there is an emphasis on the knowledge drawn from the individual cases. According to Smith (2004), an IPA analysis should allow the reader to parse the data in two ways, allowing for a group level of understanding, together with an understanding of some of the idiographic features.

Larkin *et al.*, (2006) highlight how researchers are frequently attracted to IPA for its accessibility, applicability and flexibility. IPA allows for some elements of theory development (through locating a participant's views in an empirical context) and constructivism (through observation of the use of language and non-verbal cues during the interviews), whilst focusing on the individual's story. In addition Smith and Osborn (2003) recommend that IPA is *'especially useful when one is concerned with complexity, process or novelty'* (p. 53), all of which are factors present within the current study.

2.2 Interpretative Phenomenological Analysis (IPA)

IPA was founded on the principles of Jonathon Smith and his colleagues (Smith, 1996; 2003; 2004; 2011) and is concerned with the in-depth exploration of personal lived experience, what that experience means to participants and how participants make sense of that experience (Smith *et al.*, 2009). IPA is interested in exploring experience in its own terms and involves immersing oneself in the participant's 'lived experience', but goes further than more traditional descriptive approaches by interpreting this account. The interpretative nature of IPA is informed by the theory of hermeneutics. IPA supports the idea that people try to understand their experiences; therefore the accounts provided by participants will include their efforts to make sense of their experience (Smith *et al.*, 2009). Experience cannot however be directly ascertained from the minds of participants, rather it is dependent on what the participant tells us about that experience, as well as the researcher's interpretation of the participant's account and how they understand the participant's experience (Smith, 2011). Thus the analysis in IPA is based on two layers of interpretation, referred to by Smith and colleagues as a 'double hermeneutic' because:

“..The researcher is trying to make sense of the participant trying to make sense of what is happening to them.” (Smith et al., 2009, p 3).

Analogous to most qualitative research, IPA attempts to work inductively, without a clear testable theory. Information gathered comes directly from the participants with no agenda set by the researcher (Reid *et al.*, 2005). IPA is committed to the detailed examination of the particular case; from this idiographic perspective participants are considered as experts in their own experiences, thoughts and interpretations. IPA's core concerns are psychological: - Smith (1996) proposed IPA as an approach to psychology which captures the experiential and qualitative, without having to be imported from other disciplines. Since its inception IPA has been of increasing popularity as a qualitative research method and has been gaining momentum within healthcare and psychological research (Smith, 2011). The majority of work has been done on health psychology; (e.g. Marriott & Thompson, 2008); however IPA has also been used in clinical research. Recently, Chouliara *et al.*, (2010) used IPA in a study which aimed to explore the experiences and perceptions of talking therapy for adult survivors of childhood sexual abuse. The participants in this study were both survivors of childhood sexual abuse, as well as professionals working with them.

2.2.1 Theoretical Underpinnings of IPA.

The theoretical roots of IPA are grounded within three important fields in the philosophy of knowledge phenomenology, hermeneutics and idiography (Smith *et al.*, 2009). Phenomenology is concerned with lived experience and how people acquire knowledge about the world (Willig, 2001). Phenomenology affirms that knowing is inseparably connected to experiencing and that it is not possible to develop knowledge without the experience of perceiving and interrelating with phenomenon within our context (Willig, 2001). Hermeneutics is the theory of interpretation, and despite being separate from phenomenology, the two are linked closely, particularly through the work of Heidegger, who describes phenomenology as a hermeneutic enterprise (Collins & Selina, 1998). Both share the underlying assumption that interpretation should be approached from a multi-perspective vantage point. Idiography has been described as the study of individual persons although originally it served a wider function as the study of 'specifics' (in contrast to nomothetics, the study of 'things in general' (Larkin *et al.*, 2006)). In the context of IPA,

idiography can be conceptualised as drawing on both these meanings, thus IPA strives to be idiographic, both in terms of focusing on the individual and on a specific topic area (Larkin *et al.*, 2006).

IPA has its theoretical origins in the writings of the philosophers Heidegger, Husserl, Merleau-Ponty, Satre, Scheimermacher and, Gadamer who provided the foundation of modern phenomenological and hermeneutic approaches (Smith *et al.*, 2009). Husserl's work separated from positivism of and instead emphasised the subjective experience as being the basis of all knowledge of objective phenomena. He proposed that what we perceive as 'reality' is in fact more accurately understood as what the majority of people think: the norm rather than any real 'facts' about the world (Larkin *et al.*, 2006). This corresponds with the ideas of Thomas Kuhn who asserted that the concept of scientific truth, at any particular moment in time, cannot be established only by objective criteria but rather is demarcated by the consensus of a scientific community (Kuhn, 1962). Heidegger went on to comment that the human being is always inextricably a 'person in context', with their point of view consistently influenced by their own self-identity (Blatter, 2006). This relates to the concept of intersubjectivity, which refers to the shared overlapping nature of one's engagement in the world (Collins & Selina, 1998). These concepts led to the development of the interpretivist approaches present in qualitative thinking, which are central to IPA.

2.2.2 Principles of IPA.

IPA is a method that can be used to explore personal meaning making, but which also remains sensitive to a social context. Although there is an emphasis on expressing the 'voice' of the participant, this is only the first-order analysis and half of what the method endeavours to do. IPA recognises the skills of the researchers with their background in social sciences and knowledge of the literature, and allows them go beyond traditional phenomenological approaches to interpret the findings in context (Smith *et al.*, 2009). Analogous to the process of psychological formulation, the data is considered in the light of the social, cultural and theoretical backgrounds which are present around the individual (Larkin, *et al.*, 2006). IPA can be useful in mental health research because it shares some of the principles of the social cognitive paradigm (Chouliara *et al.*, 2010).

Husserl, Hiegegar and others support that what is objective and what is subjective is difficult to tease apart (Collins & Selina, 1998). In IPA there is a recognition that despite the analysis being based on the participant interviews, the accounts can never be truly first person. Instead it will always be constructed by both participants' and researchers' interpretations, and will be based on their personal perception of the experience of a phenomenon, as opposed to an attempt to create an objective statement of the phenomenon itself (Larkin *et al.*, 2006; Smith & Osborn, 2003). The interpretative analysis allows the researcher to conceptualise what it means for the participant to have particular claims and concerns about their experience within the particular context (Larkin *et al.*, 2006). There is a great deal of flexibility in how a participant's account can be interpreted, which is sometimes referred to as 'epistemological openness' (Larkin *et al.*, 2006). While in many respects this can be regarded as advantageous, it is however important that interpretation remains grounded to a recognisable core account (Larkin *et al.*, 2006). Existing theoretical concepts can be drawn upon, as long as this can be kept directly related to the specific line of enquiry.

Hermeneutic approaches see the knower and known as inextricably interrelated (Tappan, 1997). It is acknowledged that IPA is a joint product of researcher and researched and to some extent guided by the interests of the investigator (Smith *et al.*, 1997). Throughout the research exercise it is important that the researcher's framework is noted and viewed objectively. All researchers find themselves within their own social, political, psychological and cultural context, which will undeniably influence their analysis (Nightingale & Crombie, 1999). The reciprocity between text and context is what Heidegger called the 'hermeneutic circle' (Collins & Selina, 1998). The final stage of the analysis and the completion of the 'hermeneutic circle' is a review of the interpretation, where the researcher considers the interpretation critically and amends it accordingly (Smith and Osborn, 2003)

2.3 Translating IPA theory into practice

Knowledge about the foundations and principles of IPA should be carried into the practical execution of the research by guiding the design, sampling, data collection, and analysis of the data.

2.3.1 Sampling

It is recommended that in-depth IPA analysis is conducted with a small number of participants (Larkin *et al.*, 2006). Smith and Osborn (2003) examined the issue of sample size and deduced that a clear guideline cannot be stipulated as many factors come into play. Small and large sample sizes bring their own advantages and disadvantages. A small number of samples may enable a more in-depth interpretation and analysis of each discourse, however, it may constrain the breadth of experiences and expectations to be explored. Larger samples may generate more themes, however, richness of individual experience may be lost (Smith & Osborn, 2003).

Homogenous samples are recommended: the basic logic being that if one is interviewing a relatively small number of participants there is little sense in thinking about having a randomised or representative sample. IPA uses purposeful sampling as a means of obtaining as homogenous a sample as possible (Smith *et al.*, 2009). It is possible to generalise findings to the existing psychological literature, draw conclusions and help to shed light on the existing nomothetic research (Smith *et al.*, 2009).

2.3.2 Data Collection

Due to the fact that IPA is concerned with seeing the world from the perspective of the participant, semi-structured interviews are considered the most appropriate form of data collection (Smith *et al.*, 2009). Participants are viewed as the experiential experts on the topic in hand and the use of open-ended questions allows the participant to navigate the conversation towards topics that are relevant to them. Smith *et al.*, (2009) offer some guidance on the sorts of prompts that can be used, and the appropriate situations in which to use them: for example, to probe for additional details, to clarify what the participant is saying, or to bring an aspect of the participant's account to completion.

2.3.3 Analysis

An IPA study involves a detailed case-by-case analysis of how individuals perceive and make sense of their experiences. IPA endeavours to both understand the participant's perspective and to critically evaluate it. This entails reading past the words themselves and aspiring to reach a deeper meaning of what is being said (or has been omitted). This process leads to a further analysis of meaning of a participant's narrative in the context of what we know about them, their social and cultural context and psychological theory. The interpretation is therefore both 'empathic' and 'questioning' (Smith and Osborn, 2003, p51). It has been described as working within two interpretative positions, a hermeneutic of empathy and a hermeneutic of suspicion (Ricoeur, 1970); the former seeking to sensitively understand meaning as it appears, the latter taking a more critical approach to interpretation as one might do in psychoanalysis (Landridge, 2007). Inferences can be drawn from the way in which an individual chooses to answer questions in a particular way or with a specific focus, and by means of emphasising or repeating certain aspects of their experience (Smith & Osborn, 2003). What the participants are saying is thus viewed as being connected to their psychological world: their underlying cognitions, emotions, assumptions and the context in which they exist.

Rather than providing a rigid set of rules, IPA proposes to offer a set of guidelines for analysis (Larkin *et al.*, 2006). It is offered more as a theoretical standing than a practical guide, however some guidance does exist (Smith *et al.*, 2009). The following process is the synthesis of descriptions of IPA analysis from Smith (2007), Smith *et al.*, (2009) and Smith (2011).

Following verbatim transcription of the data, researchers should familiarise themselves fully with the dataset by reading and re-reading the transcripts and immersing themselves in the dataset. The transcripts are subjected to a thorough case-by-case systematic qualitative analysis. Initial notes are made, and at this stage the researcher must keep an open mind and note anything of interest within the transcript. Comments can be made in the margin which can take the following forms as they develop: descriptive comments, linguistic comments, conceptual comments (which is the start of interpretation) and deconstruction (re-interpreting, looking for other possible meanings). The next stage involves the researcher transforming these comments into emerging themes. These should look to capture concisely the essential features of the initial readings and should not be too

general, in order that the complexity within the data is maintained. Convergence and divergence within participants' accounts should be noted. The process of analysis is iterative and interpretation of the data begins with the researcher thinking about what these themes might mean for the participants within the context in question.

As much as possible of the knowledge of themes acquired from the first participant is 'bracketed' during the analysis of the following participant's transcript. This is analogous to the way in which the researchers must endeavour to bracket their own pre-existing knowledge of clinical theory or practice during initial analysis of transcripts to avoid influencing the themes identified. Data can then be looked at in the broader context of other participant's data as well as the researcher's knowledge of the literature. The aim is to embed the participant's viewpoints in a context, with the hope of producing a more interpretative account.

2.4 Quality Assurance

There has been considerable discussion about the assessment of quality, reliability and validity in qualitative research. The reliability of a study can be increased by involving a second researcher examining the data and developing themes. Themes can then be compared for the consistency of interpretation. In some cases this can involve a numerical value of the extent to which accounts correspond (Armstrong *et al.*, 1997). However this assumes that there is a correct interpretation of the data, which is inconsistent with the principles of phenomenology. Checks on quality are clearly important and Smith *et al.*, (2009) propose that the ability to audit the process can provide an alternative. Audit can mean providing a paperwork trail to map each stage of the research process. Audit can also involve a second researcher regarding the coded transcripts and resulting themes, with the intention of checking the analysis is rigorous, as opposed to coding the data themselves. Sections of four of the transcripts were given to the Clinical Supervisor as a form of auditability to confirm themes were coherent and transparent. The flexibility of this method comes with some unfastening of both its theoretical standing and the guidelines for its practical application. The relative newness of the approach comes with the advantages of original and novel ideation, and the disadvantages of less practice and experience in its application. These disadvantages have been criticised as being drawbacks

to the use of IPA and highlight the necessity to follow the methodology as strictly as possible. In conducting this study the research followed the recommendations laid out by Smith (2011) to ensure quality (see Table 1).

Table 1. IPA quality evaluation guide showing what are considered ‘acceptable’ and ‘good’ IPA studies (taken from Smith (2011)).

Acceptable IPA studies:

The paper meets the following four criteria:

- Clearly subscribes to the theoretical principles of IPA: it is phenomenological, hermeneutic and idiographic.
- Sufficiently transparent so that the reader can see what was done.
- Coherent, plausible and interesting analysis.
- Sufficient sampling from the corpus to show density of evidence for each theme:
N1-3: extracts from every participant for each theme.
N4-8: extracts from at least three participants for each theme; and
N>8: extracts from at least three participants + measure of prevalence of themes, *or* extracts from half the sample for each theme.

Overall the paper is judged sufficiently trustworthy to accept for publication and include in a systematic review.

Good IPA studies:

Paper must clearly meet all the criteria for acceptable. It then offers these three extra things:

- Well-focused, offering an in-depth analysis of a specific topic;
- Data and interpretation are strong; and
- Reader is engaged and finds it particularly enlightening.

Overall the paper could be recommended to a novice as a good example of IPA.

2.4.1 Reflexivity

Reflexivity is something that brings an awareness of the researcher’s own contribution to the construction of meanings, within and throughout the research process, along with the

realisation that such meanings are tied to the research process, along with the realisation that such meanings are tied to the particular social context in which they emerge. Reflexivity will be utilised within this study in the acknowledgement of the role and indivisibility of the researcher (and the research context) from the research findings. Reflexivity will also be utilised to bring an additional perspective to the research, which may deepen the analysis overall. Such concerns are based on an acknowledgement that research augments experience rather than simply reflects it (Beer, 1997).

2.4.2 Transparency of the researcher's perspective

Integral to the process of IPA is making the perspective of the researcher transparent throughout analysis. It is therefore important to note the researcher's own professional and personal impetuses for conducting this research.

My experiences working as a clinician in the area of substance misuse psychology have strongly influenced my choice of research area. I have worked with a number of men and women who have substance misuse issues and histories of complex trauma and have found that frequently these individuals do not fit well into substance misuse services. I have felt that often their histories of complex trauma have not been adequately acknowledged within services, and they have been stigmatised due to the complexity of their presentation and the assumption that they are very difficult to work with. I have felt that often a tension exists between service needs for economic viability with the desire to progress clients quickly through treatment, and the complex needs of this population. Also if clients are referred out to a specialist trauma service (of which very few exist), they are frequently bounced back to the substance misuse service because of their substance misuse issues. In light of these experiences I felt that this was a very important piece of research to conduct.

2.5 The Procedure

2.5.1 Ethical Issues

The proposal was submitted to the local chair of NHS Lothian, Ethics Committee, who advised that IRAS approval was not required (see Appendix I). A submission was

subsequently made to the Research Ethics tutor for the Clinical Psychology Programme who advised that a level one audit was sufficient, and this was duly logged with the School of Health in Social Science. Management approval for conducting the research was sought from NHS Greater Glasgow & Clyde, NHS Lanarkshire, NHS Lothian and NHS Tayside, and was granted (see Appendix II).

2.5.2 Recruitment

Participants were identified through the researcher attending the BPS Scottish special interest group for substance misuse psychologists and briefly introducing the research project. An email was then sent to every qualified substance misuse psychologists across the four included Health Boards. Individuals that presented themselves as possible participants were emailed a participant information sheet and a consent form for viewing (see Appendix III). If participants still wished to take part they were asked to email the researcher for the purpose of organising an interview. Participants were assured of their right to withdraw at any point during the research process (see Appendix III).

2.5.3 Participants

Eleven participants, eight female and three male, were recruited from four health boards in Central Scotland. Substance misuse psychology is a small speciality and in order to promote participants' confidentiality minimal personal details were taken. The pseudonyms and the age-range category participants were situated in are given below:

Table 2: Summary of participant's age-ranges.

Pseudonym	Age-Range Category (in years)
Angela	45-55
Bob	35-45
Charlie	35-45
Dani	35-45
Estelle	25-35
Kate	35-45

Louisa	25-35
Rose	35-45
Rowena	25-35
Sharon	35-45
Tom	35-45

All meet the inclusion criteria, but none of the exclusion criteria, as outlined below.

2.5.4. Inclusion and exclusion criteria.

The inclusion criteria were that participants must be qualified clinical or counselling psychologists working within the speciality of substance misuse. Participants were required to have a current or recent caseload of clients that met the checklist criteria (see Appendix V) for a history of complex trauma. Participants were excluded from taking part in the research if they were non-qualified psychologists.

2.6. Data collection.

2.6.1 Development of the Interview schedule

The semi-structural interview schedule was created after broad reading of IPA principles and the recommendations of Smith *et al.*, (2009). It was appraised in consultation with the study's academic and clinical Supervisors. In accordance with the principles of IPA questions were as open-ended as possible. The interview schedule was designed as a guide that aimed to allow an open discussion so the participants could talk with minimal prompting. It was hoped this flexibility would enable participants to discuss matters that they considered to be important and that the researcher may not have expected and otherwise may have missed (Smith *et al.*, 2009).

2.6.2 Interview

The researcher arrived at the participant's place of work on the day of interview. It was important that before commencing the interview the participant was put at ease and a rapport was built. The interview proceeded in accordance with the interview schedule and

prompts were used flexibly as recommended by Smith *et al.*, (2009) in order to allow the participant to direct the conversation. Empathy and flexibility are considered vital aspects for the IPA researcher, and the researcher endeavoured to be empathic throughout the interview in order to help experience and understand the perspective of the participant. Flexibility is also crucial and the researcher strived to be able to adjust her responses and ideas according to what she heard. The researcher also kept a reflective diary in which she documented additional information that she considered important, including her own thoughts and feelings which could be used in the analysis. The interviews were recorded using an Olympus DS-2400 Digital Voice Recorder and lasted between 43 and 104 minutes. The digital recording was downloaded immediately when the researcher returned to the work place. The recording was saved onto the researchers password protected drive on a secure NHS computer.

2.6.3 Pilot interview

A pilot interview was conducted in order to trial and refine the interview schedule and offered an opportunity for the researcher to familiarise herself, practically, with the suitable balance between non-directive questioning and maintaining the focus of the interview.

2.7 Process of analysis.

2.7.1 Transcription

The interviews were transcribed using appropriate Olympus software. Following this the recording was deleted from the digital voice recorder.

Since the analysis is concerned with semantics, transcribing is recommended to include all words spoken, plus false starts, laughs, pause, etc. (Smith & Osborn, 2003). A minimally modified version of the coding system recommended by King & Horrocks (2010) was therefore used for the transcripts (see Appendix VII).

2.7.2 Coding

Data was coded following the guidelines offered by Smith *et al.*, (2009). The researcher read and re-read the transcripts in order to immerse herself within the text. The researcher made initial notes of salient points and cross referenced these with her reflective diary. The focus then shifted from initial note taking to a more in-depth analysis which applied psychological concepts to help make sense of meanings within each individual account. Themes were given titles which endeavoured to preserve the voice of the participant. Although this was an interpretative process critical care was given to remain true to the original text. The researcher then looked across themes attempting to connect these to form higher-order themes through a process of abstraction, subsumption and polarisation. Themes were brought together under naturally occurring 'clusters'. Once this was completed for one participant the researcher moved onto the next participant and the process was repeated in a cyclical fashion (see Appendix VIII for an example of coding).

Once coding was complete for all eleven transcripts themes were developed across participant accounts by looking for recurrent patterns. Based on guidance provided by Smith (2011), a theme was only considered recurrent if it occurred in at least half (six) of the transcripts and only these themes were documented. Each superordinate theme occurred in every participants account and was related to the subthemes which in turn, were connected to the original extracts from the participant. The table of superordinate themes was then translated into a narrative account where findings were interpreted within the context of the researcher's knowledge and the empirical account. Illustrative quotes were used to ground themes within the text; the ones selected were so because they displayed the essence of themes or because they presented the most powerful expressions of themes.

2.7.3 Consideration of computer aided analysis

NVivo 9 (QSR International) is a software package designed to assist qualitative data analysis. The decision not to use a software package like NVivo 9 was made for a number of reasons. Firstly, the researcher attended an IPA workshop facilitated by Paul Flowers (a co-author of the seminal key text on IPA *Interpretative Phenomenological Analysis: Theory, Method and Research*) where the issue was discussed and he recommended against using NVivo, warning that it can interfere with looking at the overview of the data. Other authors

have advised that there are disadvantages to the use of software programmes such as NVivo for those new to research as the analysis can become driven by the programme rather than the chosen methodology (Barbour, 2008). IPA makes frequent reference to '*staying close to the material*' (Smith *et al.*, 2009, p7) and there was concern that some of the immersion in the data may be mislaid if computer analysis was applied. Furthermore the relatively small number of transcripts involved in this study meant that the advantages of using a software package may not be as relevant as could be the case with a larger sample.

2.7.4 Consent

Participants were emailed an information sheet and consent forms (see Appendix III & VI) a minimum of twenty four hours before the interview was scheduled to take place. From the outset it was made explicit to participants that they could withdraw at any time without reason. Prior to the interview commencing participants were given a paper copy of the participant information sheet to re-read, and if they still wanted to go ahead with the research they were asked to fill in and sign the consent form.

2.7.5 Confidentiality

Substance misuse psychology services are generally specialist services with relatively few members of staff working in them. In order to increase issues of confidentiality participants were recruited from four NHS substance misuse psychology sites across Central Scotland. Data was anonymised by removing the participant's names which were replaced by pseudonyms subsequently used in the direct quotes extracted from the accounts. Any details which could be used to identify participants (such as place names) were also removed. The researcher was the only person who listened to the recordings. This process followed the principle of beneficence which has been outlined by Orb *et al.*, (2000), and aims to promote the well-being of participants and avoid harm that may occur through revealing the identities of participants. In accordance with NHS policy the transcriptions will be kept securely for a period of five years and will then be destroyed.

2.8 Quality assurance.

Methods traditionally used in quantitative research to ensure quality such as randomised sampling, objectivity and generalisability are not appropriate for qualitative methodology (Yardley, 2000). However, as with any type of research qualitative studies must adhere to quality checks appropriate to the methodology. Smith *et al.*, (2009) recommend Yardley's (2000) work as a foundation for quality checking. Yardley shares similar criteria to others in the field (e.g. Elliot *et al.*, 1999), however she expands the categories used and endeavours to make them relevant to any qualitative research irrespective of ideological background (Yardley, 2000). Yardley (2000) has outlined a number of principles that underpin good quality research. These are: sensitivity to context, commitment and rigor, transparency and coherence, and impact and importance.

2.8.1 Sensitivity to context

All research is situated within a context and sensitivity to this context refers to a secure grounding in the methodology of choice, sound background knowledge of the social and cultural influences on the population used in the study, the context of the researcher and the relationship between the researcher and participant. The underpinnings of the methodology in the current study have been discussed in previous sections and will not be re-iterated. The context in which the interviews took place was at the participant's place of work. The relationship between the researcher and participant was also considered. Some participants had been known to the researcher previously in her capacity as a supervisee or colleague. It was perceived that this had potential advantages and disadvantages. The researcher tried to make the interview process as informal as possible and endeavoured to address any potential disadvantages arising from this by being as transparent within the research process as possible.

2.8.2 Commitment & Rigour

This refers to ensuring a comprehensive and thorough approach to data collection and analysis. Yardley (2000) proposed that '*prolonged engagement with the topic*' (p221) is essential, and this has also been something emphasised by other authors (Lincoln & Guba, 1985). Prolonged engagement refers to more than solely the study; it also includes

personal or professional affiliations with the topic (Yardley, 2000). The researcher has worked for four years as a clinician in a substance misuse service with clients, some of whom have had histories of complex trauma. The researcher is committed to working with this client group and towards the improvement of services for them. The researcher also attended some IPA supervision sessions facilitated by a prominent researcher in the field.

The researcher familiarised herself with the methodology and attempted to immerse herself in it through extensive reading on IPA. Consultation with the Academic and Clinical Supervisor and seeking advice from a prominent researcher in the field were also important parts of the research process. The initial pilot interviews functioned as a safeguard to monitor any potential difficulties with the interview process which had not been anticipated. Conducting a good interview is considered a demonstration of good rigour (Smith *et al.*, 2009).

2.8.3 Transparency & Coherence

Transparency relates to the auditability of the research. The transparency of qualitative research is frequently more difficult than that of quantitative research as the findings are inherently linked to the interpretation of the researcher themselves. The current study was subject to independent audit by the Clinical Supervisor on three transcripts and an audit trail of all documentation relating to the study was kept throughout. This documentation process means that it would be possible for a third party to independently audit the pathway of the study and follow each step through to its conclusion (Smith *et al.*, 2009). The researcher documented all processes involved in the section above, thus providing a thorough step-by-step account of what was done. Reflexivity of the researcher is also regarded as a crucial aspect of transparency, this is particularly important in IPA as the researcher must acknowledge and detail their position in the study. To uphold a reflexive stance, the researcher kept a reflective diary throughout the study.

Coherence refers to the presentation of findings that are consistent with the theoretical background and the research questions. To maintain this, the researcher's Clinical and Academic Supervisors checked samples of transcripts with the analysis process and reviewed drafts of the write-up of the study.

2.8.4 Impact & Importance

Impact and importance is the contribution of the current research findings to theoretical knowledge and its translation into practice. Yardley (2000) states this to be the 'decisive criterion' by which any research should be judged and references to this principle are included within several quality appraisal checklists for the evaluation of qualitative research (e.g. Critical Appraisal Skills Programme [CASP], 2002; Mays & Pope, 2000).

It is anticipated that this research-which highlights the experiences and perspectives of psychologist working with substance misusers with histories of complex trauma - will offer new insights into some of the issues that can arise in working with this population, as well as into the challenges that clinicians may come up against. As previously discussed recent research suggests that individuals with complex trauma histories form a large proportion of individuals seeking help with mental health services, particularly with respect to substance misuse services, yet proportionally there is little research exploring experiences of working with these individuals. Also a great deal of the research that does exist for substance misusers with histories of trauma focuses solely on PTSD, which may not adequately accommodate the potentially more complex needs of clients who have suffered prolonged, interpersonal trauma, frequently from an early age. This population remains relatively hidden within the research literature and it is hoped that this study will help bring this issue to the forefront of clinicians' and researchers' minds. It is also hoped that this research will help to improve the established practices with this client group through dissemination of the findings to psychologists and other professionals within and outwith substance misuse services. Yardley (2000) highlights the fact that because qualitative methods emphasise people in their own context, they can prove more efficacious as the transfer from research to practical application reduces. In addition to service development it is hoped that the dissemination of results will help provide the participants themselves a sense that their voice is being listened to and heard and can have an impact. Beneath is a quote from a participant who the researcher felt captured the importance of this study:

'It just shows how much needs to change if there is gonna be a wider recognition of.. em, trauma and complex trauma, in society as a whole, but is getting there now slowly, I mean

you're doing a research project like this, it's really important, on lots of levels and for society as a whole more people need to pay attention to it' (Dani, p12).

3 Results

3.1 Overview of super-ordinate themes:

This chapter outlines the themes which emerged from the data analysis following comparison of individual accounts. Six superordinate themes were identified: Challenges inherent in negotiating therapeutic relationship, Balancing relational forces, Walking the tightrope of comorbidity, Lack of Understanding (about complex trauma), Emotional Impact of Work and Core role of therapeutic relationship. Each superordinate theme is represented in Figure 1 below. In accordance with guidelines provided by Smith (2011), all superordinate themes were evident in the interviews of all the participants and each subtheme was discussed by at least half of the participants (a minimum of six participants). Superordinate themes and their subthemes are presented here using verbatim extracts to illustrate each. Figure 1 (below): Overview of super-ordinate themes and their subthemes



These super-ordinate themes and their sub-ordinate themes are fully outlined in the passages below.

3.2 Super-ordinate theme 1: Challenges inherent in negotiating therapeutic relationship.

All participants talked about the issues involved in negotiating a therapeutic relationship with these clients. There was a perspective across participants that this was one of the most challenging aspects of their work. The three sub-ordinate themes within this were: *Mistrust as barrier*; *Promoting consistency and boundaries* and *Relationships and risk*.

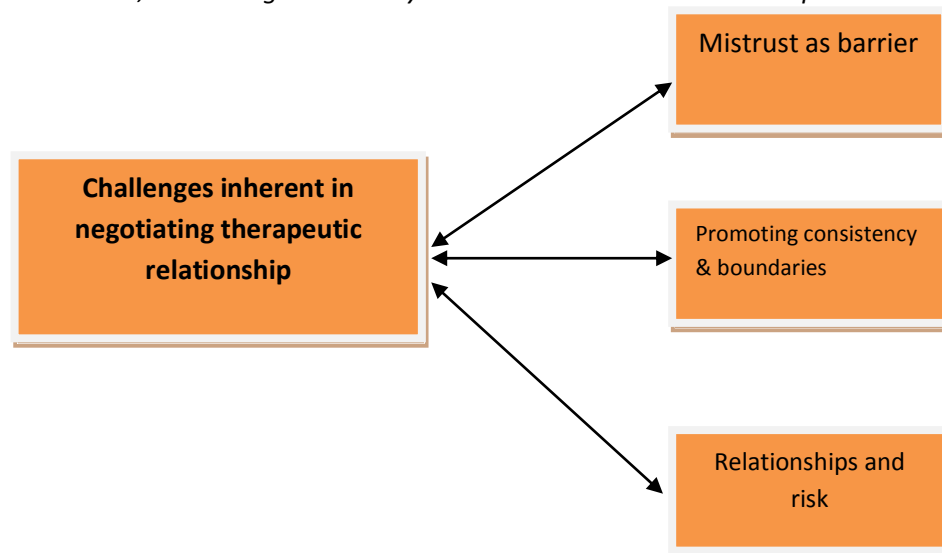


Figure 2: The sub-ordinate themes related to *super-ordinate theme 1* 'Challenges inherent in negotiating therapeutic relationship'.

3.2.1 Mistrust as barrier

This was a strong theme to emerge from all of the narratives. Many participants felt that engaging clients within an empathetic relationship was dependent on developing a sense of relatedness with them; however participants felt client mistrust was one of the principle barriers to doing so. Participants emphasised their opinion that as these clients had often experienced betrayal in their most significant relationships, their ability to trust others had been seriously and adversely influenced.

By virtue of the complex trauma their trust in people is absolutely shattered, and so being able to build a therapeutic alliance, and have them develop some kind of trust in you as a person and as therapist to be able to help them is the most significant thing. (Bob, p5)

Bob highlighted what he perceived to be the dual nature of psychologists. First and foremost they are people and it is on this human level that he and other participants assumed that clients trust had initially been damaged, and therefore it was from their position of being human that trust initially needs to be founded. Many participants conjectured that clients' lack of basic trust was so intrinsic that it should not be underestimated, and in fact they should expect to be distrusted by clients:

..but I think it's really a willingness or acceptance for..., to respect the client's right to completely distrust me. (Charlie, p2)

However not everyone found it as easy to accept. Rose appeared to struggle with resigning herself to being distrusted. She seemed to feel that not being trusted conflicted with her identity as a psychologist and her perception of herself as a kind and trustworthy therapist.

The mistrust can be really horrible to deal with, I mean I'm a psychologist, I'm not gonna hurt anyone. (Rose, p5)

It could be interpreted that by appearing to take personally a client's distrust, Rose had underestimated how pervasive this issue can be with this client group. It appeared she was bringing her own set of assumptions to the relationships, which were at odds to her client's assumptions.

The difficulty that people have in trusting other people, and actually that's coming from quite a solid background of evidence on their part not to trust people, and they may have never trusted anyone.., so it's huge to try and overcome that with them, before you can do any other work. (Sharon, p2)

Like Sharon, many participants inferred that building trust is the foundation upon which the therapeutic relationship is built, as well as the belief that without it other work cannot progress. An analogy can be drawn between participants' perspective about the role of trust in therapy and Erickson's (1980) conceptualisation of the role of trust in development.

Erickson (1980) considers the building of basic trust to be the earliest developmental task, upon which all others are built. Some participants believed that at times they were forming what clients' experienced as their first ever trusting relationship. Thus negotiating trust was perceived as being as difficult as it was vital.

There was a disparity within participants' perspectives of how they endeavoured to overcome mistrust within the therapeutic relationship. Some felt that initial work should be person-centred with emphasis upon empathic reception of and resonance with changes in the client inner states. These participants seemed to share the assumption that focusing upon therapeutic tasks and techniques could cause therapy to become myopic, with content being given precedence over process. The participants assumed they would appear more genuine and trustworthy if they were to focus upon forging a sense of relatedness and connection.

I think if you were to be technique focused, you know, you're not gonna get very far. There's not enough trust usually with people who have experienced this kind of early relational trauma, em, so they don't trust enough to be able to actually adopt the strategies in the first place.. em, so I think you have to be more real, and as I say it has to be very much relationship focussed. (Estelle, p1)

However, in contrast to this viewpoint Rose perceived that it was better to try to build trust in a more implicit manner through the use of familiar and predictable therapeutic tasks. She believed that trying to increase intimacy levels with clients early on in the therapy process can heighten their levels of anxiety:

Rather than having just focus on our relationship, you know to kind of, let the relationship develop while you're almost task orientated. So it feels a safer way of doing it, a less threatening way of doing it. (Rose, p2)

It is interesting to speculate who Rose is referring to when she says it's a *safer way of doing it*. At one level she appears to be referring to her belief that it is safer and less intrusive for clients. However, when interpreted from another perspective she could mean that it is safer for her, in that this way of working can serve as a defence against emotion and more gruelling complex and unpredictable relational processes.

Clients' disconfirmation of, and lack of trust in themselves was discussed by many participants as another manifestation of how their mistrust could act as a barrier against the negotiation of the therapeutic relationship.

They don't trust their own perceptions; so it's like one step forward and two steps back.
(Dani, p8)

She doesn't trust her own thoughts, and if she doesn't trust her own thoughts then how on earth is she going to trust me? (Angela, p 7)

Some participants seemed to assume that clients would start to develop trust in them, but then would doubt their own judgements and default back to a position of mistrust. Participants conceptualised this within the context of clients' histories and surmised that often abusers may have encouraged clients to '*deny their own emotional reality*' (Louisa, p6). A minority of participants appeared to assume that it was naive to expect that mistrust could be overcome within the therapeutic relationship (at least early on). This belief appeared to be betrayed by Angela in the above extract through her use of a questioning tone. This opinion clearly has challenging implications for the negotiation of therapeutic relationship, particularly if trust is considered to be the foundation of therapy. It also implies a feeling of futility within these psychologists. Most participants, however, assumed that they could gradually earn reasonable levels of trust from clients over the course of therapy, although they considered this process took a substantial amount of time.

It takes such a long time for them to realise that you can be trusted. Usually, when it's complex trauma I think, you don't seem to get the outpouring as much, it seems to be more the dripping tap kind of phenomenon, you know, one session they'll come in and tell you a little bit, and then the next session then come in and say, oh and this happened as well, so you'll first of all find out maybe that they've been in a violent relationship, but it's not until like several sessions down the line that you find out there was actually sexual abuse during childhood. (Rowena, p 1-2)

Some participants described how they were not always informed or aware of the full extent of a client's trauma history at the onset of therapy. It appeared that often participants felt

that complex trauma issues were only disclosed after a trusting therapeutic relationship had been developed. Rowena's extract suggests that to some degree she felt her client was testing her in that she was only telling Rowena little bits of information at a time and gauging her reaction before she made the decision to disclose more. Other participants discussed feeling that at times these clients were testing them. Thus in some instances it appeared that participants would only become aware of overcoming client mistrust through the process of disclosure itself.

The distress and sense of betrayal that a history of complex trauma and subsequent substance misuse entails was perceived by participants to promote feelings of mistrust of others and disdain of themselves within these clients. These were thought to act as barriers to the formation of the therapeutic relationship.

3.2.2. Promoting consistency and boundaries

The process of establishing and negotiating the structure and boundaries of the therapeutic frame was considered by all participants to be particularly challenging and critical with these clients. Participants appeared to believe that because these clients' trauma histories were predicated on complete violations of psychological and physical boundaries, they were both particularly sensitive and vulnerable to boundary blurring or violation within the therapeutic relationship.

The nature of complex trauma is your boundaries have been so smashed to bits (Charlie, p23)

All participants assumed that in order to establish a sense of safety it was very important to find ways of maintaining boundaries which clarified what clients could consistently expect and count on in therapy. Most participants conjectured that the process of establishing boundaries was confusing and frustrating for these clients. However, as is exemplified in Rose's extract, participants perceived that a sense of consistency helped to build trust in the therapeutic relationship. Most participants discussed how they would try and see these patients at the same time and same day every week in order to promote this consistency.

But having that kind of erm awareness right from the start, that their appointment time is their appointment time, and although that can be quite challenging for them. I think it also

brings them an element of safety which can start to translate into their understanding of the relationship being in some way something they can trust (Rose, p1)

All participants perceived that these clients had little understanding of how normal boundaries are set and maintained in healthy relationships. Some participants believed that because of this it was important to explicitly discuss boundaries in their work with this client group. They assumed that these discussions would help to define the therapeutic relationship as a mutual process in which all interactions, including their own behaviours and decisions were open for review.

Cos it's very rare that people will have had a collaborative healthy relationship, so I think you have to very aware of what that is and what that feels like and maybe bring that into sessions, em, discuss it, have a think about what's OK and what's not OK, em, where are the boundaries, where is it OK to have the boundaries, why might it not be OK to have boundaries in certain places. (Dani, p12-13)

Discussing boundary issues was felt by some participants to provide an opportunity for the explicit negotiation of basic components of interpersonal relationships within the context of the therapeutic relationship. Some participants perceived that for clients whose needs had been historically used as a means of exploitation, the process of discussing boundaries can be revelatory, and can model that collaboratively boundaries can be made stable enough to allow clients to protect themselves, and flexible enough to respond to their needs. Participants considered some aspects of the therapeutic frame to be fixed and unchangeable, however others were considered subject to negotiation between participants and clients over time.

..they might have significant trauma histories and need to stand outside having a fag and, therefore, they're not gonna be in the reception room when they're called. So go lets go outside and get them, lets treat them with respect, you know they've made a huge step in seeking help, let's try and facilitate that help (Bob, p 6-7)

Bob, like the other participants considered that boundaries are subjective and personal. He postulated that in the negotiation of boundary issues psychologists need to be aware of complex dynamics concerning their own and a client's particular fears, wants and needs. It can be interpreted that Bob believed psychologists being flexible with the boundary issue of where a client waits before therapy, could mean the difference between these clients

engaging in treatment or letting their trauma related fears about sitting in the waiting room disrupt their chances of doing so.

Participants perceived that careful attention to the boundaries of the therapeutic relationship provide the best protection against difficult to manage transference and countertransference reactions. Some participants discussed how they often found themselves reaching out further in work with these clients compared with others, and discussed being drawn into what they appeared to conceptualise as attempted replication of the enmeshment or violation inherent in clients' earlier experiences.

..there are issues around overstepping boundaries, and this in one patient group where it's much easier to do harm, than I think with other patient groups, inadvertently, not deliberately. (Kate, p29-30)

Kate and the majority of other participants perceived that there is a high propensity to do harm with this client group compared with other clients. It appeared that they felt that an awareness and understanding of the potential intricate relational and transference dynamics, which may emerge in work with these clients, was essential in order to minimise damage. It can be interpreted that participants' diligent consideration of boundary issues was one of the ways that they tried to translate this into practice.

I don't think she'd ever been in a relationship, any form of interpersonal relationship with a man, with any semblance of a boundary. Men she was used to would either succumb to her feminine wiles or beat her within an inch of her life, or want to have sex with her... So you might be quite seduced I guess in that sense, feel quite seduced, or you might have sexualised feelings towards the patient I mean I think that's quite common, people don't talk about it a lot do you know, but I think it's very common, and how do you deal with that? How do you deal with that when someone is quite traumatised? You know, that's complex work, that's like lots of supervision. (Charlie, p22-23)

All of the male participants were conscious that many of these female clients grew up with experiences of having fused caring and sexuality. There was awareness that some women had historically used sex as a means of developing and maintaining relationships with men, which was perceived as having important implications for work with a male therapist.

These participants described how, when this transference is present within the therapeutic relationship, it can be very difficult to work with and can evoke complex, and sometimes even erotic feelings within them. Sexualised countertransference is a common experience, particularly for male therapists working with female clients who have been subjected to sexual abuse (Shrum, 1989; Siegel, 1996). Charlie discussed his perception that despite this being a difficult and taboo subject, these types of issues need to be worked through openly and without shame within supervision. He appeared to believe that open discussion and acknowledgement of these complex relational dynamics can normalise them and minimise any possible boundary-related risks that can be associated with this complex work.

Although participants shared the perspective that there was the potential for harm to be done to clients through boundary violations, they equally held the opinion that if boundaries were too inflexible they could also be damaging for these client:

I guess some workers, psychologists included, can be punitive with clients. Yeah we have to put into place boundaries, but I think that we as addiction teams are often quite quick to not see the client's perspective and boundaries can actually become too strict. (Bob, p6)

Bob considered that in substance misuse services boundaries were frequently too rigid. It appeared that under these circumstances there was the potential for the therapeutic relationship to replicate a client's earlier patterns of relationships and could lead to the underlying reasons behind their behaviours being not taken into consideration.

All participants perceived that the negotiation of boundaries was a core ingredient of therapy with these clients; however, there appeared to be many factors that needed to be considered in this process. Participants conjectured that boundaries needed to be firm enough to enable clients to feel safe and to avoid the violation of parameters that are essential to effective treatment, but at the same time it was important for them not to become so inflexible that the human-to-human element of therapy was lost. Thus part of this work appeared to be constantly striving for the right boundary balance. Rowena's comment captured participants' dilemma:

Part of them needs routine and a structure and consistency, but part of them also needs to not have that and to have space (Rowena, p5)

3.2.3. Relationships and risk

Discussion about negotiating the therapeutic relationship took place within the context of participants perceiving these clients to consider relationships in general to be risky. There was an understanding from participants that often clients had developed a set of beliefs about interpersonal relationships that were likely to work against the formation of collaborative relationships, the therapeutic relationship being no exception. Rose appeared to interpret clients' reluctance to enter into the therapeutic relationship via her understanding that in doing so clients act in opposition to their ingrained instincts to flee from relationships:

So with individuals with complex trauma, where most will have.., the danger will relate to being in a relationship, or close to another person, or being around another person. So that then is gonna lead them to want to run a mile from being close or in a therapeutic relationship, so a therapeutic relationship itself can be a really unsafe thing, a risky place for people with complex trauma (Rose, p13)

In attempting to overcome a client's trepidation about the therapeutic relationship, some participants described striving to be acutely sensitive to client's needs. They described employing conventional therapeutic techniques and methods, endeavouring to apply them with scrupulous care, (note Estelle's repetition of the word very).

When I'm trying to form a relationship with these clients I know I they are gonna find it really hard.., so I try to be very very much in tune to how..,how I come across in terms of body language and tone of voice, so maybe have quite a soothing tone of voice, you know speaking quite slowly. I also make sure I employ all the basics like empathy, warmth and unconditional positive regard (Estelle, p1)

However, in contrast to this perspective, other participants perceived that these practices, which were typically advantageous for developing a therapeutic relationship with other clients, were not necessarily effective with this client group:

Funny things start to happen when you're forming a relationship with somebody in terms of their attachment styles or what it provokes for them.., and I think, sometimes, I think all I need to do is be this warm caring friendly caring person and they'll be fine to engage with that. But I think that can be really challenging for these people sometimes, to have

someone be that way with them. Almost in a way they're used to someone being shitty to them, and they're more familiar with that em.. and they know how to deal with that more easily than somebody being kind and caring., and that can trigger all sorts of things for people. I'm not sure I completely understand what's going on. (Tom, p3)

Note Tom's use of the expression *funny things*; despite being an experienced psychologist he used this rather colloquial tone of phrase to describe his experience and in doing so alludes to his feelings of uncertainty which he clarified in his final sentence. Many participants discussed how they thought that being empathetic and supportive with these clients was often outside of their normal repertoire of relationships, and could have a contradictory effect.

You can't assume that just being with them, being there and being ourselves in a kind of congruent empathic and non-judgemental way is gonna be enough. I don't, I don't think that that is enough with our clients that have complex trauma and substance misuse, for various reasons. I think it can be a really challenging process for them when they're sat with someone who wants to kind of be close to them I think, or form a relationship. I think that can be terrifying for them, and actually might make them run scared. (Rose, p2)

The process of negotiating a therapeutic relationship with these clients was experienced by participants as being perplexing and challenging. They appeared to feel their basic assumptions regarding therapeutic work were called into question, and that their experience of negotiating the therapeutic relationship conflicted with their typical experiences with other clients. Although participants were striving to provide a warm, reliable, consistent and trustworthy relationship, they appeared to believe that paradoxically (as a result of clients' disorganised attachment styles) such a context might feel risky, rather than comforting to the client. There was disparity across participants' accounts about how best to navigate this dilemma and it appeared that some participants were unsure about the best approaches to employ with these clients.

He was really quite open about the fact that, you know, he didn't want to call me by name because he didn't want to see me as a real person, because that would mean that he had developed some kind of relationship with me. (Sharon, p3)

By not using her name and thinking of her as something other than a real person, Sharon assumes that the risk that the client normally equates with relationships could be circumnavigated. Sharon, however, experienced this as confusing and contradictory as she appeared to feel that she was developing a growing sense of relational stability with him.

Participants perceived that these clients' backgrounds had distorted their ideas about relationships and these mind-sets were brought forward in both the treatment relationship and process. Careful attention and awareness of this issue was considered to be an integral part of therapy with these clients.

3.3. Superordinate theme 2: Balancing relational forces

All participants discussed the potential relational challenges inherent in working with this client group. Clearly participants did not believe that these clients have a homogenous interactional style; however, certain patterns emerged across participants' accounts which were remarkably consistent. The two sub-ordinate themes within this were: *Push and pull dynamics* and *Tensions inherent in assuming parenting role*.

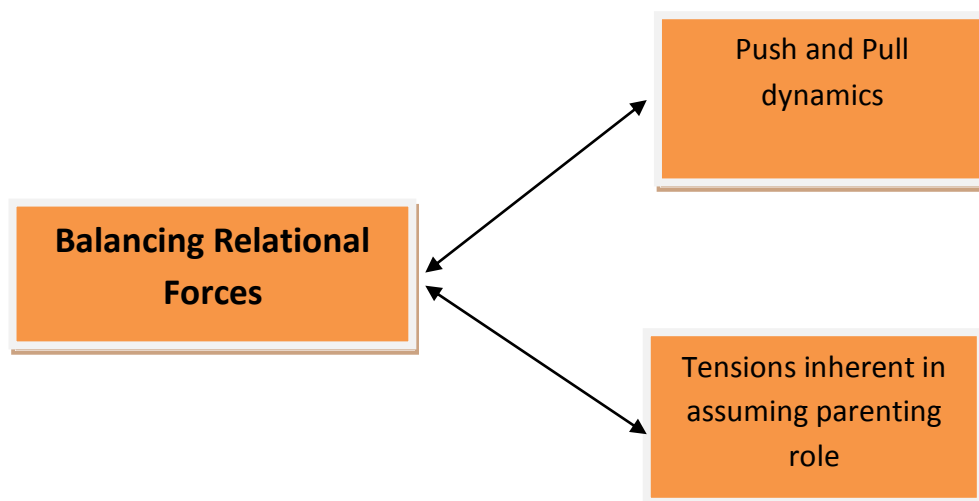


Figure 3: The sub-ordinate themes related to *super-ordinate theme 2* 'Balancing relational forces.'

3.3.1. Push and Pull Dynamics

All participants described a sort of approach-avoidance dynamic (Chu, 2011) or what Rose named a '*pushing pulling dynamic*' (p8) that frequently transpired in work with this client group. The relationship dynamics appeared to be experienced as ever changing. Kate

compared it to being on '*shifting sand*' (p7), just as one position is assumed it is quickly lost. Many participants appeared to consider that it is precisely at the moment when clients felt most positively about them, that the therapeutic relationship was ironically, but understandably most laden with associations of abuse or neglect (Courtois, 2010). This was understood by participants as being one of the reasons for clients acting in (what they felt) was a self-protective manner and rejecting the psychologist in one form or another. Liotti (1992) describes how the major roles that are often recapitulated within the relationships of abuse survivors are the three incompatible roles of abuser, rescuer and victim. He proposed that these should be viewed as being a metaphorical rendition of contradictory emotional (frequently preverbal) schemata that arose during the interactions that lead to their disorganised attachment. This can be seen to have implications for therapy; the drama triangle (Karpman, 1968) offers an explanation for the roles that participants described as being repeatedly taken on by clients and themselves in this work:

That kind of pushing pulling kind of dynamic and that sense of I suppose, kind of what I'd describe as times when you feel that they can't get enough of you, they need you, and you're the only one, and there's times when you kind get spat out and really rejected. (Rose, p8)

One minute you're her best pal and you're on this pedestal and the next minute, ah you're this and you're that and she hates you and she's not coming back.. I've had a couple of people storm out, a couple of people who have just got up and walked out of sessions. (Rowena, p10-11)

The intensity of the experience of these dynamics was captured in Rose and Rowena's extracts as they illustrated their experiences of being quickly shifted from what can be considered the role of being held in high esteem as 'rescuer' to be utterly rejected as 'victim'. Some participants believed that often these clients were not able to consider them to have both strengths and weaknesses concurrently, but instead can only either idealise or denigrate them. Kate's experience of being pushed into the 'victim' role is illustrated below:

Other times I become the.. the person who's the victim if you like, or the survivor, you know, and the person will come in and be really blaming of me, and really angry with me and it's my fault.., and I've got anxiety and feelings of shame and I want to make it up.., and

I'm thinking, oh, hang on a minute, I'm wondering if this is what you felt like as a child.
(Kate, p20)

Kate's extract also illustrated something discussed by other participants; that these dynamics become an intricate and important part of the therapeutic process and can be used as implicit communication to gain insights into a client's experience of self and of others. Tom's account can be interpreted as using waves as an analogy to help him to comprehend his experience of these vicissitudes. He appeared to perceive that he had to ride the waves of these relational dynamics, keep perspective and avoid being sucked into the current of them:

It's a tidal kind of thing, you just have to sort of hang in there and understand the process
(Tom, p7)

Despite recognition of these push-pull dynamics, not becoming enmeshed in them appeared to be experienced as 'easier said than done' (Rowena, p13) by many participants. Louisa talked about being pulled into positions that were mirroring those of her clients, where she oscillated between contrasting emotional positions:

So it's a kind of flipping between em, kind of feeling really quite protective and feeling really quite annoyed (Louisa, p14)

Sharon described how on this occasion she had extended herself beyond her traditional boundaries because she felt that it was important to do so; however she then felt guilty for doing so and as a consequence of her guilt retracted from the client:

I felt it was important, but then other colleagues told me I had gone too far and the I felt guilty and I think then I took a massive step back (Sharon, p4)

Sharon's movement from a position of over-involvement to withdrawal could be interpreted as her potentially replicating the client's family patterns of inconsistent and vacillating relationships and thus further contributing to her experience of push-pull dynamics.

The majority of participants held the assumption that because clients have been hurt so many times in relationships they had developed conflicting ideas about people being caring, but also being abusive. This appeared to lead them to hold the view that these clients enter treatment with mixed feelings of hope and fear (similar to that which has noted independently by Herman, 1992, 1997 and Price, 1994). Rowena highlighted her assumption about the perspectives of these clients as being:

..they want help but they can't cope with the help. (Rowena, p16)

This ambivalence was perceived as being played out in therapeutic relationship through these push and pull dynamics.

They're trying to make their way in the world, where they're terrified of relationships and have a longing for and need for relationships and a kind of disorganised attachment style, which is one of the reasons why the dynamics are so unstable. (Charlie, p13)

Many participants perceived that because of their histories these clients are compelled to precipitate abusive re-enactments which can be played out during therapy. Acknowledgement of this was perceived by participants to help them avoid misinterpreting the intentions behind clients' interpersonal behaviours and not take them personally. However participants found it challenging to avoid being drawn into these complex relationship dynamics and have at times found that that had unwittingly been so.

3.3.2. Tensions inherent in assuming parenting role.

Often in direct response to what they considered to be clients' expressed needs, participants perceived they could be drawn into assuming a parenting role within the therapeutic relationship. There was, however, disparity between participant's accounts, and while some viewed assuming a parenting position as constructive, others felt contrary to this. Thus a sort of tension between the participant's experiences was evident.

I suppose when I'm trying to engage someone, in some way, in some ways I almost sometimes feel myself becoming in some ways quite like a parent in some senses. (Estelle, p1)

Estelle's repetition of the word 'some' in the above extract could be interpreted as suggesting that she did not want to commit herself fully to identifying with the parenting role in her relationship with clients, and felt some ambivalence about doing so. Some participants believed that assuming a parenting role could perform various functions which may be beneficial for clients, who they perceived may have never received good enough parenting earlier in their lives.

I think there's a lot of re-parenting type work that happens, and I think it becomes almost like a parenting relationship and I think that the service provides this kind of, in some way it's about being unconditionally positive and supportive, but in the other sense it's about providing quite firm boundaries about what is OK and not OK.. They often have never had this before. (Tom, p8)

Tom perceived that a parenting role can be used by the service to help teach clients what is appropriate and acceptable and what isn't, in a supportive, yet bounded way. Charlie assumed that the concept of the child within the adult can be a useful metaphor to apply to these clients, within whom he felt a particularly pertinent vulnerable child state exists.

You have to see the child within them; however, you can turn into an authoritarian parent.., put them into the victim child mode, which is odd even though you're trying to completely avoid doing that. (Charlie, p19)

In assuming a parental role Charlie was concerned that there was a risk of unintentionally taking on an authoritarian role. He appeared to believe that if this became the case, it could infantilise the client, deny the adult functioning part of them and re-enact client's punitive childhood dynamics. Some participants discussed other concerns about adopting a parenting stance:

It can be a bit like parenting but of course there's a risk of it being omnipotent, that's quite a risk because you can just become an expert friend, or an expert parent and you take the person away from you and they go off and behave in their usual ways again. (Angela, p21-22)

Angela discussed the danger of adopting an all-powerful, all-knowing position within a parenting role. She appeared concerned that this could lead to a denial of a client's power and self-authority, as well as encourage overdependence. This she perceived could preclude a client's opportunity to develop their own internal resources and ultimately lead to them resorting back to old behavioural patterns when therapy was terminated.

How do we help that client develop an internal working model in which they can validate themselves, validate the emotional experience they're having and self soothe without us becoming a parent? And I think that is the main goal of doing em, trauma working within addictions population, and that's, the most significant thing, that we don't become a parent, I don't think we set out to be a parent, but I think that quite often, in a kind of transactional analysis way, we're kind of drawn into that relationship, and then in that dynamic it's very easy for us to.., for the client to see us as being very critical, punitive, and that gives them a reason to react against that and disengage and use more substances, for me that's always something that I'm trying to be mindful of, I guess the transference issues, god, I don't know, yeah..'(Bob, p5-6)

Bob supposed that often these clients cannot calm or comfort themselves by calling up a mental image of a secure relationship with a caregiver. He appeared to feel that during the process of trying to help change clients' inner working models, it was therefore easy for psychologists to be pulled into this unoccupied good parenting role. It could be interpreted however, that he assumed that if psychologists take on this role they can become entrenched in actual, behavioural confirmations of clients' transferences and it could be easy for clients to see them as transference parent figures. Bob conjectured that based on clients' histories, this could lead them to perceive psychologists as a potential source of harm, control and criticism. Bob seemed concerned that in a direct response to these potential transference responses, there was the risk that clients may act in defiance against the psychologist as a perceived authority/ parental figure, use more substances and possibly discontinue therapy. He therefore was clear in his opinion that adopting a parenting role is something that psychologists should avoid doing; this opinion was also shared by Dani:

I think sometimes services can get into an almost quite a parenting role which I believe should be avoided, you know you're behaving badly, you know, you're letting me down, a lot of clients will come and say I've used again, I'm really sorry I've let you down, and it's not

about that, it's not about anything to do with you, or their addiction worker, or whoever, it's about whether it's good or bad for them (Dani, p15).

Dani appeared to believe that an 'I know what's best for you' attitude, which may emerge through the adoption of a parenting stance, can have negative implications for therapy. She also seemed to think that clients can become attuned to what they perceive are the needs of therapist. In these circumstances it can be interpreted that Dani believed there was a risk of re-creating a dynamic of role reversal⁵. Dani figured that under these circumstances there could be the potential for therapy to become misaligned and become more about what the therapists perceived needs are, as opposed to the client's actual needs.

The differences between the participants' views illustrate the importance of subjective understandings and opinions within the treatment context. They also emphasise how the participant's own perspectives effected the treatment that these clients receive. These psychologists were not providing therapy based on some universally agreed criteria about what roles they should and should not adopt, but rather were directing the therapy process according to personal views and opinions.

3.4. Superordinate theme 3: Walking the tightrope of comorbidity

All participants talked about the challenges involved in working with client's co-occurring substance misuse and complex trauma issues. The three subthemes within this were: *Needing to work in an integrated way?* *Fundamental relationship to attachment difficulties* and *Risking re-traumatisation and relapse*.

⁵ Role-reversal generally refers to children taking care of their parents and is an issue that has been documented in the literature and being a role that abused and neglected children are frequently forced to assume (Macfie, et al., 1999)

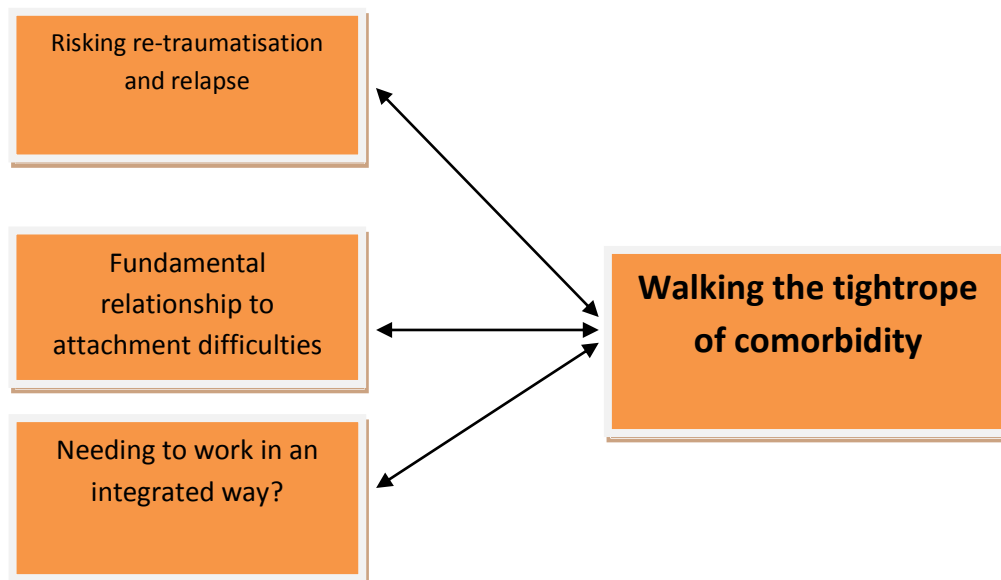


Figure 4: The subordinate themes related to *superordinate theme 3* ‘Walking the tightrope of comorbidity’

3.4.1. Needing to work in an integrated way?

The majority of participants felt that a client’s history of complex trauma and difficulties with substance misuse were fundamentally interrelated. Substance misuse was conceptualised as an attempt for clients to manage the devastating effects of complex trauma on multiple facets of their lives. Kate’s choice of the word *symptom* (rather than, for example, consequence) in the following extract could be seen as highlighting how intricately linked she perceived these difficulties are for clients:

I see the substance-misuse as a symptom of the complex trauma. (Kate, p20-21)

Participants believed these comorbid difficulties needed to be addressed concurrently in therapy. There was a general awareness among participants that this view contradicted the traditional philosophy about treatment (which is that substance misuse issues need to be addressed prior to trauma work). The traditional approach to therapy was, however, perceived as lacking appreciation of how clients may find it seemingly impossible to remain substance free because of trauma-based physiological responses, emotions, thoughts and relationship patterns.

You can't just take away the coping mechanism and expect it to be filled with nothing.
(Dani, p15)

Dani believed that in the absence of any other coping mechanisms, when clients stopped using substances and attention was not given to the underlying trauma symptoms, they would find it very difficult to control their trauma related responses and behaviours. Many participants perceived that this led to a paradoxical situation where frequently these clients would be compelled to start 'using' again as soon as they had reached their goal of being substance free. It was, therefore, assumed to be unrealistic for some clients to try and become completely abstinent from substances until they had been taught alternative coping strategies. Although there was a consensus amongst participants that they would not work with clients who were intoxicated or 'high', most reported working with clients who had been stabilised on a particular level of substances, for example methadone or benzodiazepines⁶. The practical challenges of working with clients who were under the influence of substances were considered to be very difficult to address and sometimes it was unclear to participants whether clients had used extra substances on top of their prescriptions:

A lot of people are on benzos⁷, which is really difficult because half the time they can't remember what they've told you, or they can't tell you anything because they're so spangled. (Rowena, p13)

Most participants experienced that clients being under the influence of substances had multiple implications for their work and effected issues such as clients' attendance, memory, inhibition and ability to concentrate. Participants appeared to be unsure how to position themselves within this issue, and complained that there were '*no clear guidelines*' (Rose p12) advising when and how to best engage with clients who are continuing to use substances.

⁶ Many clients attending substance misuse services may be stabilised on prescriptions of methadone or benzodiazepines for considerable periods of time. When this is the case they are considered to be 'stable', although it is difficult to establish if they are buying higher doses of these drugs illegally on the black market as drug screening tests just show what drugs an individual is using, but cannot indicate the quantity.

⁷ 'Benzos' is a colloquial shortened term for the category of drugs benzodiazepines.

Bob believed that it was a psychologist's responsibility to work with substance misuse and complex trauma issues in an integrated manner. He appeared to hold the perception that based upon their training and formulation skills there was no excuse for psychologists to work in a non-integrated way, despite acknowledging that to do so was difficult:

No frankly you have to deal with both of them simultaneously, that's difficult, I think, that's *extremely* [emphasis] difficult, dealing with the addiction issue and the trauma issue, certainly that's what psychologists need to do (Bob, p10).

Like others, Louisa believed that substance misuse and complex trauma sequelae could magnify each other in a sort of circular fashion. She felt that it was important for clients to learn about the synergetic nature of their difficulties:

When they occur together they are intensified. I suppose it's about trying to work with both together actually look at how one thing might trigger off the other. (Louisa, p13).

Understanding the reciprocity of the disorders was further discussed by Charlie:

So that you treat in a trauma-informed, integrated way, so that you don't compartmentalise the difficulties out, em, and I suppose if you're working from a process based therapeutic approach, you're constantly assisting the process by assisting the person to become more aware of their own processes all of the time..., so they're getting the insights, they're getting the realisations, they're making the connections between these kind of separate islands of thought..., or these separate islands of things they think aren't linked, and they get more of a sense of control and efficacy so that they can learn a greater sense of self-control rather than the false illusion of control using substances (Charlie, p16-17).

Charlie professed that clients need support to understand the connections between their current patterns of substance misuse and their attempts to manage complex trauma sequelae. It can be interpreted that he assumed loss of self-control to be inherent to both substance misuse and complex trauma, and that understanding the dynamic of control was essential for successful treatment. Charlie, like all other participants surmised that trauma informed substance misuse services need to be integrated services. He conjectured that

the problems of substance misuse and complex trauma interact in complex ways within clients' minds and lives. He seemed to believe that integrated working enables clients to focus upon common issues, offers integrative explanations and teaches comprehensive skills in order to help manage both difficulties concurrently. Thus Charlie advocated that it is only through integrated treatment that these clients could be helped to establish greater real control and self-efficacy in their lives.

In contrast Tom expressed his desire to be given instruction about which of the two difficulties to treat:

If we get somebody referred to us with substance misuse and complex trauma, we need to work with them in an integrated manner, but I think the service has to be quite clear about whether our role is to treat the substance misuse or the complex trauma, em, in as much as the complex trauma is quite long term work and requires a certain kind of a approach and the substance misuse is slightly different. (Tom, p 10)

Tom's perspective about what integrated work entails can be interpreted as having become paradoxical in nature. Integrated working means continually integrating attention to both disorders at the same time and it is difficult to see how this can be done if they are addressed separately. Tom's perspective exemplified how in practice the issue of integrating treatment of substance misuse and complex trauma can become misconstrued and problematical in nature.

All participants assumed that clients' histories of complex trauma had played some role in their substance misuse difficulties. By virtue of the complex and varied connections between the two disorders participants felt treatment needed to operate in an integrated way. However sometimes it appeared that in practice this was easier said than done.

3.4.2. Fundamental relationship to attachment difficulties.

Many participants discussed how they conceptualised a client's comorbid difficulties to be fundamentally related to their difficulties in attachment relationships both past and present. Participants thought that survivors of complex trauma had great difficulty developing and maintaining long-term positive relationships and believed that consciously

or subconsciously they would seek the ease of a relationship with substances above the unpredictability of human relationships. In contrast to their experiences of real life relationships, participants assumed that clients saw substances as being predictable, reliable and there to make them feel better:

I think that many people find addictions particularly attractive because they can trust their addictions more than they can trust people. (Estelle, p11)

Some participants surmised that these clients used substance misuse as a (misguided) attempt to try and increase their internal sense of safety and need for comfort, in the absence of real life supportive attachment relationships or internal representations of them. Clients were also perceived as using substances to help manage volatile and self-demeaning relationships because being under the influence of substances was considered to function as an anaesthetic to current mistreatment:

I guess our clients quite often just don't have that internal working model to turn to, you know, they need to self soothe.., they need to manage the harsh and abusive relationships in their lives.., and the only things that does work is the substances or the drink. (Bob, p5)

Bob's extract can be interpreted as highlighting his perception that substance misuse can contribute to immobilising clients from leaving damaging relationships, and thus to the continuation of violence and interpersonal trauma in their lives. Participants found it difficult and distressing to work with somebody for an hour a week when for the rest of the time they are being exposed to relationships that are keeping them traumatised and stuck.

It's astonishing over the years, the number of people I've heard, use different analogies for that same thing, who have addiction problems, who have complex trauma, they talk about this emptiness, or this hole in themselves or this lack, and how they discovered substances, and oh, hey presto, they thought great, that seems to be that piece of the jigsaw that was missing, I feel confident, I feel great, but then it wears off and I'm back to feeling the way that I feel, so all the other stuff is symptomatic, the way that they are in relationships, the types of relationships they pursue, the difficulties they have in their lives, I think is all interlinked really to that real core attachment stuff that is at the root of complex trauma. (Charlie, p17)

Like Charlie, many participants described how they thought that substance misuse was used by clients to fill their inner sense of emptiness and in an attempt to heal attachment wounds caused or exacerbated by trauma. This is similar to the perspective of Walant (1999), who regards substance misuse to be a secondary substitute for attachment, which is adapted as a means of coping with the traumatic effects of early, and unmet developmental needs. Although participants assumed that substances may initially, and in the short term, be used by clients as the solution to all their unmet attachment needs, they surmised that their effects would soon wear off and clients would ultimately become addicted. Participants conjectured that it would not take long for clients attachment-related difficulties to become magnified by the lifestyle connected to substance misuse.

Substance misuse in turn makes relationships more difficult.., em as addiction takes hold.
(Louisa, p 2)

The nature of addictive processes were perceived as including a falling away from any existing or potential positive attachment relationships as the addiction gained power and control. Participants felt that clients' substance misuse behaviour eroded their potential for positive relationships, as they spent more time meeting their addictive needs and less time nurturing their relationships. Therefore, although participants believed that many clients perceived substance misuse as a solution to their problems, participants themselves perceived it as another consequence of clients' impaired ability to develop healthy attachments. In a deviation from this viewpoint and in contrast to the other participants (who perceived these clients as generally being very socially isolated), Angela described her view that substance misuse can be a way for clients to gain social contact.

A lot of them are using drugs/drink because that's the only way they get social contact so we say to them oh, you've got to change all your friends, and throw away your mobile phones. (Angela, p18)

It was unclear why Angela's narrative showed this divergence, although one explanation could be that she spent time working with clients in their '*late teens and early twenties*' (p5). This could be considered too early in the trajectory of a substance misuser's life for the potential destructive effect of substance misuse on relationships to fully take hold. The majority of other participants were working with clients with longer standing problems.

Many participants felt that treatment approaches would only be successful if they involved clients connecting with other sources of support outside of the therapeutic dyad. Tom conjectured that if clients remained isolated they would slip back into substances. He appeared to conceptualise that forming healthy relationships with other people was an essential part of the process of recovery for these clients.

If you can develop maybe a support system around them, if you can do that.. or get others in the service to help, but I think without having people around them, they are just gonna retreat back into substance misuse and it's all gonna become a mess, again (Tom, p13)

Tom, however, appreciated that the conventional role of a psychologist dictated that it was not always possible to link clients up with wider systems of support and this would require multi-disciplinary working.

Many participants supposed that it was only through a client's recognition, understanding and acceptance of the fundamental connection of their difficulties to their attachment related problems, that they would be able to remain substance free and meet their own attachment needs through healthy and supportive relationships.

He is now starting to realise that that's the only way forward for him.., that he can't let go of his attachment to substances until he has other attachments that are more meaningful for him, and will fulfil some of his needs, which are essentially just for emotional nurturance and reassurance and understanding. (Kate, p35)

3.4.3. Risking re-traumatisation and relapse.

All participants discussed the multifaceted nature of the risks involved in working with this comorbidity and how clients vulnerabilities associated with each of their problems could amplify each other, acting as precipitants for further problems.

It's kind of like walking a tightrope, clients can become re-traumatised and go into a view of, you know, being suicidal, self-harming chronically, putting themselves at massive levels of

risk in terms of substance misuse and high risk of overdose and all that kind of stuff. (Charlie, p21).

Participants experienced the potential risks of clients damaging themselves through relapse, self-harm or intended or accidental suicide as being very challenging to work with. Charlie described it as *walking a tightrope*, which can be interpreted as him meaning he has to walk a fine line of needing to approach clients difficulties, while at the same time respecting and balancing potential risks.

Many participants discussed times when they experienced the balance being tipped towards the risk side. Tom illustrated his experience with a client who had been responding well to input from other professionals within the multidisciplinary team for some time and had relapsed back onto substances after engaging with psychology for only a few sessions.

As people approach difficult psychological stuff their chances of relapse will go up, and I see that all the time. I have somebody I'm working with at the moment who was doing really well for six months, and then they come along to see the psychologist to start working on their underlying psychological issues, and they had three sessions with me and they relapsed.. and you know it's like.. well it looks really bad, it's like send them to the psychologist and they'll relapse. (Tom, p20)

Some participants perceived that simply the idea of seeing a psychologist could be very threatening for these clients. It appeared that to some extent Tom felt responsible for the fact that his client had relapsed and seemed embarrassed about how he thought it looked for his profession as a psychologist. Rowena discussed how her patient had not only relapsed but also developed agoraphobia after working with her for a few sessions, despite her tone being jocular she seemed to have found it difficult to deal with and was taking on some degree of personal responsibility herself for what had happened.

So now after working with me for a short time he's now agoraphobic ((laughs)), before he was at least getting out of his house, and he's back on heroin, and I'm like, is that me? (Rowena, p18)

Participants discussed how they felt the potential of a client relapsing back onto substances was ever present, which they appeared to experience as a persistent source of anxiety

which formed the background of this work. The risk of a client relapsing after a period of abstinence or stability was considered particularly anxiety provoking because participants were aware that it was likely that a client's tolerance would have reduced considerably, thus making the likelihood of overdose considerably higher:

There's always the risk as well, if someone's been stable or abstinent for quite a while and they do return to substances that their tolerance has changed, that's a big risk in itself. (Estelle, p12)

Another consequence of clients becoming stable or abstinent was thought to be the potential for them to become flooded by uncontrollable trauma related memories and symptoms which could then re-traumatise them.

They've stopped using, and you start talking about stuff.., sometimes they can start to remember things that they've forgot, not necessarily even buried. (Kate p27)

Therefore, as was similarly touched upon in the integrated working subtheme, stopping using substances was paradoxically perceived by participants to be a trigger for clients to relapse. This highlights the potentially self-perpetuating and spiralling nature of participant's experiences of this type of work.

A few participants talked about how the misuse of substances in itself can also increase the risk of re-traumatisation, not only through the lifestyle attached to it, but also as a result of the psychopharmacological effect of the substances on clients. It appeared that Charlie felt that part of his responsibility was to make clients aware of the potential for substance misuse to directly contribute to re-traumatisation.

If they're using something like benzodiazepines or sedatives, or a lot of grass that's got like a psychoactive substance in it, it can really increase their sense of depersonalisation and re-traumatising themselves and terrifying themselves.., it's important to help them see the links. (Charlie, p 12)

All participants felt that there were risks involved with working with substance misuse and complex trauma separately in their own rights. However when these difficulties were co-occurring participants felt risks were further magnified in a multitude of ways:

It's a very deadly combination. (Charlie, p16)

Attention to the management of these risks was considered to be an integral and difficult part of this work.

3.5. Super-ordinate theme 4: Conceptual dearth (regarding complex trauma)

All participants perceived that there was a lack of conceptual understanding and many misunderstandings surrounding complex trauma. The concept of complex trauma and its related sequelae was considered to be amorphous and difficult to pin down. This was perceived as having implication for the therapeutic dyad and the wider system that it was embedded in. This branched off into the sub-ordinate categories of: *Lack of understanding (about complex trauma)* and *Substance misuse services not set up for complex trauma*.

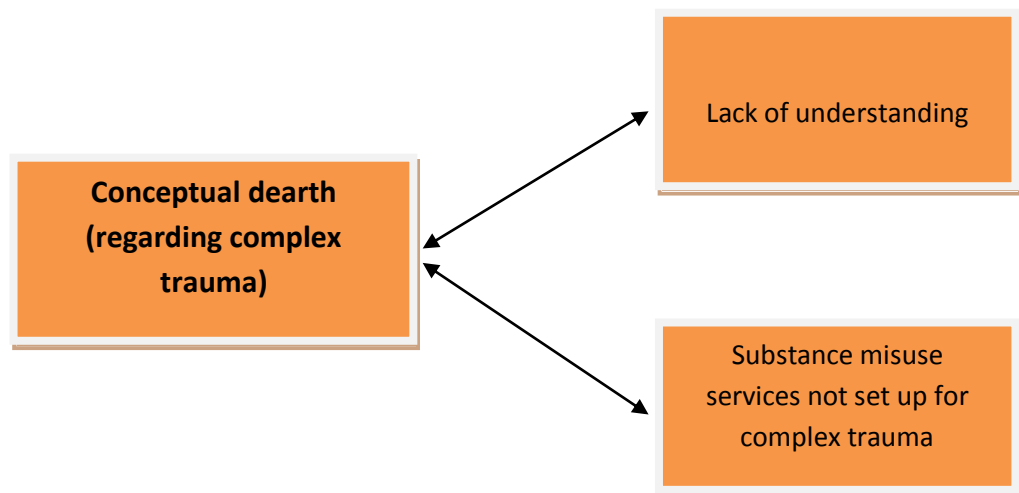


Figure 5: The sub-ordinate themes related to *superordinate theme 4* 'Conceptual death (regarding complex trauma)'

3.5.1. Lack of understanding (about complex trauma).

Many participants perceived that there was little understanding within health teams about the devastating effect that complex trauma can have on an individual's psyche, personality and relational capacity. The majority of participants considered that a lack of recognition and understanding of complex trauma was frequently associated with some of the ways of thinking and conceptualising of cases which are characteristic of psychiatry.

So I think a lot of it is that it's completely under-recognised, and if it's under recognised by our psychiatry colleagues what hope in hell do nursing, do social work, actually even the rest of psychology have? (Kate, p17)

Psychiatrists were assumed to hold a position of power and authority within substance misuse services, so participants felt that their perceived lack of awareness of complex trauma had significant implications for how clients' difficulties were conceptualised. Some participants surmised that the diagnostic categories within the existing psychiatric canon were not designed for survivors of complex trauma and inadequately accommodated the multiplicative effect of clients' experiences of prolonged interpersonal trauma:

I suppose at that level of complexity, people don't necessarily fit into diagnostic categories very easily. (Angela, p 13)

Because post-traumatic stress disorder (PTSD) is a well-established diagnosis, most participants experienced that all trauma related disorders, no matter the level of severity were conceptualised by the majority of health professionals, as being PTSD:

I think trauma is sort of understood within health teams specifically as being sort of PTSD. (Louisa, p10)

This was experienced as perpetuating misunderstandings about the nuanced and multifaceted sequelae of complex trauma. The majority of participants also conjectured that it meant that the connection between clients presenting symptoms and their histories of multiple traumas were frequently overlooked. Attempts to fit clients into the mould of more familiar diagnostic constructs was believed to lead to partial understandings of clients difficulties and a disjointed approach to treatment.

Quite often people who present with issues relating to complex trauma, it's maybe misdiagnosed it's not recognised, it might be described as severe enduring mental illness because maybe they're, maybe they're voicing that they're hearing voices, but maybe it's not about a psychosis, maybe it's about an intrusion, a traumatic memory. (Dani, p3)

Some participants discussed how they believed there was ignorance within services about the neuropsychological effects of complex trauma. They had experienced clients being mislabelled as having '*learning disabilities*' (Angela, p13) or '*alcohol related brain damage (ARBD)*' (Dani, p5) when they themselves had formulated clients' difficulties as having arisen out of their complex trauma histories. Participants perceived that this was disempowering for clients because these labels suggest their difficulties were finite and could not be improved via treatment. Another common experience among participants was that clients were diagnosed with having a personality disorder (PD). When this was the case participants felt the origins of a client's difficulties (as responses to their abusive environments), were not incorporated into treatment. Instead participants appeared to feel clients were blamed for their problems, as if they were the result of their inherent personality defects. Most participants felt that the diagnoses of personality disorders were charged with pejorative meaning which frequently influenced other professionals' reluctance to work with clients.

It's kind of seen as it's oh, its personality things and stuff and issues, and it's never really seen that the underlying layers of actually really what's going on for them, and what's occurring for them. It's just seen as too difficult to engage, too challenging, too.... all the sort of derogatory words in terms of personality disorders. (Rose, p10)

Kate perceived that these clients were so misunderstood and prejudiced within services that it was only psychologists who were willing to work with them:

These patients that look like complex PTSD and PD patients, nobody wants to work with them, apart from us it would seem, generally. So a lot of the time there isn't the system around you to support you in working with this type of patient group, not in terms of a multi-disciplinary, multi-professional group (Kate, p16).

As illustrated by Kate, some participants often felt unsupported by the wider multi-disciplinary team in their work with this client group. They appeared to feel solely responsible and accountable for these clients, which they experienced as particularly troubling due the challenging nature of this work. Although all participants discussed how this lack of understanding applied to professionals out-with psychology, many believed that

there was also a lack of knowledge and understanding within psychology, which was felt to be reflected in the evidence base:

The evidence base, which let's face it is slim to none with this client group, absolutely almost non-existent for how you work with these patients. We just don't have evidence base of what works with these type of guys..., we just don't. We have expert opinion if that. [...] So I do feel there's a bit of kind of swimming through muddy water when you're a clinician in this area, and that's clearly difficult. (Kate, p15).

Juxtaposing it with other psychological presentations many participants complained that there was a lack of evidence base to inform practice with these clients. Participants discussed how they found this destabilising and they were frequently perturbed about whether they were '*doing things properly*' (Angela, p29). Uncertainty and confusion, as well as the perception of being out of their depth appeared to be the rule rather than the exception for the majority of participants. Many participants experienced this lack of understanding was also revealed in training issues. Training about working with survivors of complex trauma was thought to be very poorly integrated into their training programmes and continual professional development (CPD). This appeared to contribute to some participants to doubt their competency to work with this client group, to feel de-skilled and believe that they required more sophisticated training devised to respond to the needs of this client group.

We need some skills, therapy skills that are you know, beyond just about being symptom-focussed..., that are about deeper core change in attachment and core change in personality. (Bob, p16).

It is interesting to contemplate how the issue of lack of training and understanding surrounding complex trauma fuse with the confused and disorientated projections from the clients and to what extent they magnify each other. For these clients' needs to be adequately met within services participants felt it was vital that complex trauma was properly understood and acknowledged within their multi-disciplinary teams and the evidence base. However, the majority of participants felt that presently this was far from being the case.

3.5.2. Substance misuse services not set up for complex trauma.

Although most participants felt that complex trauma was be *'by far the most common problem coming to addiction psychology services'* (Louisa, p9), they perceived that substance misuse services were not adequately prepared to accommodate these clients.

It's seen that we work in addictions and therefore we work around substances and that's the kind of issues, but that's totally missing the point, in fact we work in complex trauma day in day out, and that kind of has a huge impact on your capacity, or on my capacity to be able to keep working at that level. (Rose, p14)

Rose appeared frustrated with the assumption that substance misuse psychologists deal with addictions first and foremost. It seemed she felt this underestimated what her job entailed and did not take into consideration the large amount of time and energy that she spent working with clients with comorbid histories of complex trauma. Many participants conjectured that there was a lack of awareness within substance misuse services (particularly at management level) about the true nature of the difficulties that the clients presenting to them were struggling with.

'I think the managers of the service have to realise the client group that they're working with, I don't think many do. (Rowena, p6)

This was felt to have wide-reaching implications for effective work with these clients. Rowena was not alone in thinking that resources were allocated in ways that did not adequately accommodate the needs of these comorbid clients. It could be interpreted that Dani perceived services sometimes re-enact aspects of trauma models by trying to avoid the prevalence of complex trauma issues that they were dealing with, as well the emotional responses connected with this. As would be predicted by trauma-models these denied emotions would then manifest themselves in other ways and and increase levels of tension within services:

The more a service is struggling, em, with maybe an increasing level of complexity with its clients, em, you can see it, you know, services will try and avoid the emotion associated with that and everyone gets really stressed. (Dani, p9).

Paradoxically legislation relating to substance misuse services was experienced by the majority of participants as hindering rather than helping services to become more inclusive of these clients:

So from an organisational point of view, this is not good for HEAT⁸ targets, not good for HEAT targets at all, because if you think you have an eighteen week referral to treatment target.., but I don't think I've got anyone on my books that I've seen for less than thirty sessions and most of them I've seen for a hell of a lot longer than that.. And progress is very, very slow, so if someone does come into your clinic and engages, then in my view you're in for the long haul. Unless you're doing some sticking plaster therapy which is symptom focussed and actually doesn't deal with the real problem their ways of relating to themselves and others. (Kate, p 14)

Recent changes to HEAT targets for substance misuse psychologists were perceived by some participants to have significant negative implications for their work with these clients. These targets were considered to add additional pressures, particularly with respect to the amount of time participants assigned to these clients. Some participants discussed how they felt the quantity of clients they saw was given more priority than the quality of their work with them. This was believed to contribute to the '*revolving door*' (Kate, p14) experience of treatment, which has been identified as being pervasive for these clients (Najavits, 2006). A client's experience of being discharged from and then re-entering treatment was perceived as commonplace under conditions where they only received superficial treatment for their complex difficulties, and while the underlying drivers of their problems remained untreated. Tom discussed how he felt that service through-put demands also had implications for how he established a therapeutic relationship with these clients, and had contributed to him feeling ambivalent about doing so:

It becomes very difficult to think about forming a relationship with somebody who's got a complex trauma background and ending the relationship in you know, six months or something it just doesn't feel really that realistic or fair.., so I suppose the pressures of the

⁸ HEAT stands for health improvement, efficiency, access and treatment. HEAT targets are a core set of Ministerial objectives, targets and measures for the NHS. HEAT targets are set for a three year period and progress towards them is measured through the Local Delivery Plan process.

service and the system impact on how able you are to form that therapeutic relationship (Tom, p4).

Tom conjectured that if work with this client group was only restricted to the short term then one '*shouldn't be getting into it in the first place*' (Tom, p11). He appeared to perceive that in working with these clients, stopping therapy after a short time period (after trust had been established), could run the risk of replicating abuse dynamics by abandoning clients and breaking the relationship after they had formed an attachment. Thus he believed that developing a solid therapeutic relationship over a short time period (as his service demanded) was not only unrealistic, but could also be damaging for these clients. Many participants discussed how frequently the complexity of these clients' comorbid difficulties were perceived by the system as being too problematical or disruptive. As a consequence they did not think they fitted well into the way services had been developed:

Someone who is presenting with that complexity doesn't fit into services, because services are quite categorical, you know, they have inclusion and exclusion criteria, em, so someone like this, you know, probably fits a few different services, or fits none. (Dani, p4)

There was also the perception amongst many participants that substance misuse services can often deprive clients of their own authority by only focusing on negatives:

I mean these clients have survived, they have survived often the most horrific of upbringings.. and part of what has helped them to survive has been their substance misuse. Services need to recognise and give respect to that, as well as encourage clients to focus on their strengths, rather than give them derogatory labels. (Angela, p6).

Some participants thought that services needed to help clients to re-examine their behaviours in terms of the strengths that they contain, in order to help them to understand that often even their most destructive behaviours had been functional responses to abnormal situations, and attempts to survive and cope in the most adverse of circumstances. This approach was perceived by participants to be much more helpful than reinforcing a client's beliefs that there was something profoundly wrong with them. Angela appeared to consider that such a focus could inspire hope, as well as convey to clients that services believe in them and their capacity to recover.

The majority of participants perceived that several approaches in substance misuse services ran counter to principles that would effectively meet the needs of clients who had histories

of complex trauma. This contributed to participants feeling that they were inadequately supported and '*fighting an uphill battle*' (Dani, p7) with respect to their work with this client group.

3.6. Superordinate theme 5: Emotional impact of work.

All participants discussed how this type of work often had a profound emotional impact on them and this affected both their responses to clients and their decision-making processes. The three subthemes within this were: *Recognising own reactions*; *Deciding to proceed or not with trauma-focused work* and *Aftereffects*.

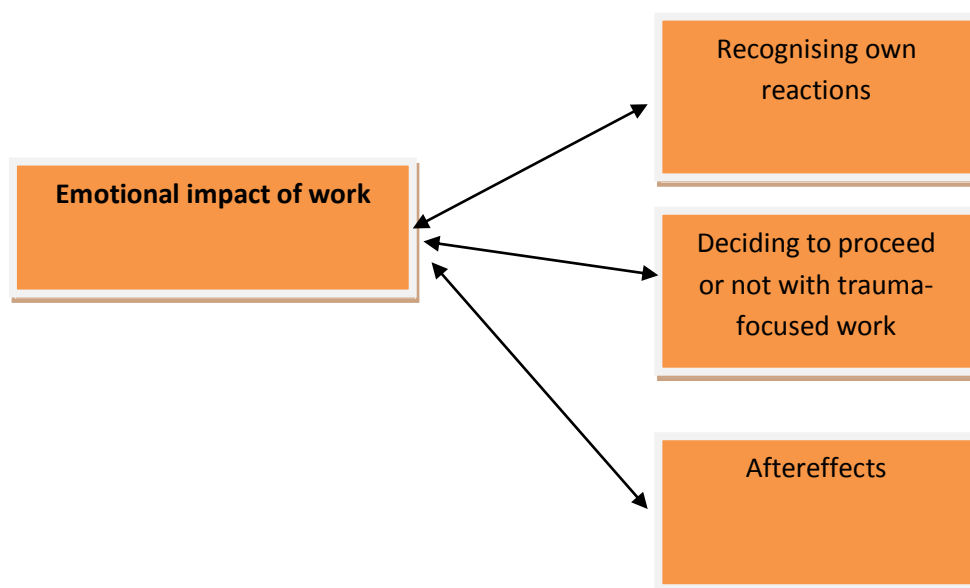


Figure 6: The sub-ordinate themes related to *super-ordinate theme 5 'Emotional Impact of Work'*

3.6.1. Recognising own reactions.

A consensus emerged across all participants' narratives that working with comorbid substance misuse and complex trauma evoked particularly powerful and complicated responses in them. Participants found that it was helpful to see the therapeutic relationship as an interpersonal arena in which both parties participate, rather than seeing solely the client and the client's responses as determining the nature of the relationship. Thus they perceived that through sharing a client's experiences they were participants as

well as observers within the therapeutic dyad. Some participants discussed how substance misuse and complex trauma have a tendency to evoke contradictory responses in them:

Trauma elicits compassion, and addiction elicits disgust.., em, and there's a lot of prejudice against addiction clients, even within services, they don't always smell nice they don't always look nice, there sometimes quite aggressive. (Dani, p16-17)

Some participants discussed how derogatory perspectives concerning substance misuse can invoke judgements and distain in people. In contrast they felt that complex trauma and the complete violation associated with child abuse, can lead to responses of empathy, care and support.

Often there's the thing about if someone's had lots of trauma you might feel very kind of protective towards them and then there's the thing about if they're using substances and maybe working in prostitution and things like that..., well, it can be really quite frustrating because they're still putting themselves in really, really vulnerable situations. (Louisa, p13-14)

Participants discussed how it can be difficult to try and balance these contradictory responses and how they could fluctuate between them within and across sessions. It appeared that participants found themselves struggling to find the right balance between support and accountability (Najavits, 2002b), a balance that was constantly sought but never achieved with this client group. These contradictory responses have been recognised by Najavits (2003) who has named this phenomena 'paradoxical countertransference'.

Participants discussed occasions where, in response to their perceptions about their clients, they had become either under-involved or overinvolved in the therapeutic dyad. Some participant discussed the tendency to pull back from clients as a method of self-protection from the painful experiences that they were disclosing:

..probably less now but early on I had to think about my own kind of barriers, to kind of developing relationships with people and having them open up about you know very horrible stuff and what that kind of evoked in me, and what that made me feel (Tom, p4).

It is interesting that Tom has embedded the disclosure of his perception of own barriers in a time frame. It could be interpreted that he felt comfortable to do so through comparing himself more positively in the present day to earlier in his career. In contrast many participants discussed how occasions where in response to their perceptions about the vulnerability of clients, they felt they had become over-involved in the therapeutic dyad. This had played itself out in a myriad of forms across participants' experiences:

I felt like his life was my responsibility and it was like I was begging him to stay in therapy, and the more I did the more derogatory he was becoming about it. (Sharon, p 3-4)

Sharon discussed how as a consequence of his trauma history she had perceived this client as being particularly vulnerable. This had led her to find herself in the position of struggling with too much personal responsibility within the therapeutic dyad. As a consequence of this it could be interpreted that the client did not have to deal with his own ambivalence about therapy, because Sharon was maintaining a positive stance and therefore freeing him up to be more negative. By getting so drawn in to these dynamics Sharon appeared to find herself in an untenable therapeutic position, which despite her good intentions, had become counterproductive to progress. Another common form of over-involvement appeared to be participants assuming the role of rescuer. Tom discussed how his character was predisposed to want to help people; hence he described how a client's self-presentation as victim could attach to his pre-existing urge to be a rescuer.

Especially as naturally I'm a bit of a kind fixer and helper, and I think sometimes the temptation when I was earlier in my career was to see all this distress and horribleness and think I could do the saving thing. (Tom, p4)

Most participants perceived that when they assumed the rescuer role they were implying that a client was not capable of looking after themselves, which they assumed could lead to further disempowerment. However despite this acknowledgment, many participants reported finding themselves drawn (unwittingly) into this role. Charlie discussed his perspective of how this over generous stance may also lead to a boomerang response, and ultimately to psychologists losing patience and tolerance. He perceived that this could cause feelings of frustration towards the client if/when they were not progressing as well as was expected.

Because of the sense of complete vulnerability that there can be with people with complex trauma, I think where therapists kind of become frustrated rescuers, frustrated with the clients. (Charlie, p3)

Feelings of frustration and anger towards clients were reported by some other participants and it appeared that they found these feelings particularly difficult to own up to and deal with. Some participants described the tendency to enact rather than talk about these strong feelings. Notice how Louisa appears to struggle to vocalise what she is trying to say. This could be interpreted as being suggestive of the potential guilt she was experiencing surrounding this sensitive issue:

I think that there can be sometimes you know.. the kinda of concern about,... almost the feeling as a clinician, I suppose, not.. (I'm trying to think how to put it into words), the thing about.., em, I'm thinking about a specific woman that sometimes it was almost like if I asked her to do something between sessions, I was doing it because she was annoying me..and it was almost like, well, you're annoying me and making me be quite punishing and taking on an abusive role or wanting to do that (Louisa, p11)

Louisa appeared to be surprised and shamed at her recognition that in trying to suppress her feelings of frustration towards her client, she was actually demonstrating them in subtle and indirect ways. Despite her best efforts it appeared that, possibly through the process of projective identification, Louisa's response towards her client had become potentially abusive, and could be interpreted that she was inclining towards the position of abuser as in Karpman's (1968) drama triangle. Anger and potentially abusive behaviour (in various guises) were a responses commonly referred to across participants' accounts, with participants finding it challenging to control their own levels of anger at times in this work. Some participants discussed their experiences of clients blaming them or being angry with them and conjectured that it was important to try avoiding retaliating with respect to feelings of wrath aroused by this.

I mean my initial reaction when she first went crazy on me was I'm not seeing her again, forget it, give her to someone else ((Laughs)).., but actually then just figuring out what it was about and what it was re-enacting. (Rowena, p29)

Rowena appeared to experience her client's explosive rage as frightening and she described how her initial response was rage and wanting to reject the client. Instead however,

Rowena accepted and legitimised her client's anger and conceptualised it as her client communicating how distressed she was. Rowena was able to view her client's response as a re-enactment of early abuse-related relational dynamics. In doing so she was able to alter her perception about her client and change her response from rejecting to understanding. Thus it can be interpreted that by emotionally containing her own and her client's anger Rowena was able to break the potentially vicious cycle of angry projections within the therapeutic dyad.

Many participants believed that acknowledging negative or difficult responses was important aspect of therapy with these clients. Doing so was seen to provide a responsive context for the surfacing of difficult and complex emotions, (which individuals may have previously been too shameful to acknowledge or had been worried about being rejected about), as well as modelling how these feelings and responses would be handled in therapy.

I would discuss it with her when she had made me angry or upset, but having her realise that it didn't matter what she said to me.., I was still gonna give her another appointment.
(Angela, p28)

It can be interpreted that Angela perceived that through openly discussing with her client how her behaviours were making her feel, (yet at the same time letting her know that no matter what was said she was not going to break the therapeutic relationship), she was hoping to communicate that all feelings were acceptable and expectable within the therapeutic arena.

Participants appeared to find it challenging to remain conscious of the complex levels of meaning and potential pitfalls in the management of their responses in work with this client group. They seemed to believe that recognising and attuning to their own responses required similar attention as was given to their individual client's responses, while they acknowledged that this could be particularly difficult to do with this client group.

3.6.2. Deciding to proceed or not with trauma-focused work.

The majority of participants discussed how whether to proceed or not with trauma-processing work with these clients was an extremely contentious and anxiety-provoking decision to make. All participants perceived that before traumatic material could be

addressed constructively, it was crucial that clients had developed the skills needed to cope sufficiently with the distress that is provoked by it. This perception is consistent with the initial phase of treatment named by Herman (1992) as 'establishing 'safety'. Many participants felt as if they were walking a fine line in the sense that they needed to approach painful memories with clients (and therefore not '*collude with their avoidance*' (Bob, p 4)), while at the same time respecting a client's fears, stability of functioning and well-being.

So when we're talking about the complex side of trauma, rather than PTSD, that actually quite often people have to go through very painful emotions to be able to move on from these experiences, and that can include anger, it can include grief, it can include lots of sadness, they can feel very distressed, very anxious, em, and I say, this may well be, I can't say for you specifically, but you need to be aware that this is not an easy process to go through, and that these are some of things we might come up against, em, and that I'm prepared to stick with that but I think they have to be aware of, I think they need to be aware of what they're getting into..' (Kate, p28)

Kate believed that it is important to be honest with clients and make them fully aware of what trauma-processing entails. She, as well as other participants surmised that it was a client's privilege and personal choice to decide whether to proceed or not with trauma-processing as part of their treatment. However, other participants believed that even if prepared, rarely would a client understand the full implications of what trauma-processing would involve. Also, in the light of these clients' backgrounds of coercion some participants were worried they may feel pressured to go ahead with trauma processing.

Is it really an informed choice.. or are they just agreeing to it because they think it's what you want? (Dani, p 3)

The decision about whether to engage with trauma-processing was experienced to be to some extent paradoxical in nature by many participants. They recognised that the recall of traumatic material was an incredibly painful and difficult process for clients and would be likely to exacerbate, rather than resolve distress and dysfunction at least in the short term. Participants also appeared concerned that they could end up recapitulating client's interpersonal pattern of subjugation and abuse:

Is there potential that in encouraging the client to be doing trauma focussed work when they don't want to be doing it, we abusing our clients? (Bob, p13)

The intensity and intimacy involved in trauma-processing appeared to heighten participants' caution about this decision. Particularly in the light of his gender identity, Charlie appeared concerned that when engaging in trauma processing and discussing such sensitive topics, there was a risk that clients could perceive him as a potential perpetrator:

Is there, is there a risk of discussing something so intimate with a client that I could potentially.. or they could see me as contributing to the abuse? (Charlie, p15)

Anxiety that clients would relapse back to substances appeared to be ever-present in participants' decisions about whether or not to begin trauma-processing work. A sense of guilt and responsibility induced by this risk appeared to increase participants' concern. Most participants perceived that these clients had rarely attained stable, effective adult functioning and as a result of this used substances to help them cope with daily life. Thus treatment approaches that concentrated on confrontation of traumatic experiences were perceived by some as being too risky and unlikely to be productive with these clients.

Getting the trauma focused work with these patients with substance misuse is not so realistic and almost in some ways there is a fear of sending people back to substances.., it's a huge responsibility (Louisa, p4).

As well as the risk of relapse, participants perceived that the nature of these clients' difficulties could lead to other significant complications for trauma- processing work. Unlike clients with circumscribed trauma histories, participants discussed how these clients by definition had previously experienced multiple traumas, and frequently went on to experience subsequent traumas as a result of the propensity for re-traumatisation within this client group⁹. Also complex trauma involves difficult to describe, evocative stimuli

⁹ Childhood victimisation has been shown to significantly increase the risk for physical and sexual assault/abuse, kidnapping/stalking, and having a family friend murdered or commit suicide in adulthood (Widom, Czaja & Dutton, 2007). Substance misuse has also been found to increase the likelihood of re-traumatisation (Chu & Dill, 1990; Desai, Arias, Thompson & Basile, 2002).

whose longer term effects on clients were perceived to be more diffuse. This meant that participants were not able to isolate a single experience of trauma to be processed and instead had to navigate through a far more complex and muddled picture, with multiple traumas being addressed at different times during the treatment process.

They have been beaten up or they put themselves in a situation where they potentially have an overdose and they have become very traumatised again, and on a few occasions I have found that quite difficult because then you're right back in the containment stage and to trying to straddle being in the middle of trauma processing for something else, so it's very difficult to shut the trauma processing down and go back to the issue. (Bob, p4)

Bob illustrated how demanding trauma processing work can be in practice with this client group, particularly when they have experienced a subsequent traumatic experience whilst already engaged in trauma processing work for a separate experience.

Cos I just think for me as a clinician, that's a struggle I always have, is how much to intellectualise and work within very safe models for me, versus working in what I think would ultimately be a more, potentially more productive way for patients, but a much more challenging way for me, and do I trust the support systems in the service I have to support me in doing that or will that actually leave me exposed and endangered myself? (Tom, p19-20)

When Tom referred to 'safe models' he was referring to Seeking Safety (Najavits, 2002) which is an approach to treating substance misuse and trauma issues concurrently, but which does not go past stage 1 (Safety) of the phase-based model (Herman, 1992) and does not involve trauma processing. Tom appeared to perceive that it was not just clients who may not be able to cope with intensity and distress associated with trauma-processing, but that he himself did not feel safe to do so. It can be interpreted that Tom believed that through maintaining a professional role that was not encouraging of exploration, he was able to protect himself. Although understandable (particularly in light of the fact that he does not feel supported enough to do this work), this approach could be seen as reflecting unwillingness on Tom's behalf to engage with distressing emotions, and hear the true nature of client's stories. This could be conjectured to contribute to perpetuating the silence and denial so often associated with child abuse.

The decision whether to proceed or not with trauma-processed work was clearly convoluted and anxiety-provoking for participants. Factors such as substance misuse, the

complexity of the trauma, the client's wishes and the therapist themselves appeared to affect this decision, with clinical lore guiding the decision and no rules set in stone. Although some participants advocated that under the right circumstances they would conduct trauma-processing work with these clients, others appeared to feel that the potential for relapse back to substance misuse and the complexity of an individual's trauma histories meant they would rarely, if ever do so.

3.6.3. Aftereffects.

All participants experienced that the cumulative effect of doing this work across clients had the propensity to result in profound personal transformations and bring about changes to their own perspectives about life and world view. Some participants described how just as clients had developed various styles of protecting themselves as a result their histories of complex trauma, so they themselves developed ways of protecting themselves from repeated exposure to traumatic material and traumatic re-enactments in this type of work. Some participants described how burnout and emotional numbing became responses to painful feelings and an awareness of pervasive human cruelty. It appeared that for some participants this blocking of pain caused them to lose touch with other feelings as well. Participants recognised that these adaptations were frequently not in the best long-term interests for themselves, clients or therapy.

I think personally I'm more in danger of becoming burnt out, or kind of defensive to it, kind of locking down, you know I've heard this story a lot, it's amazing how often you can hear about child abuse and actually find a way of that sounding normal, it's quite frightening that that can happen, that then stops becoming a shocking story. And I think there's a real danger of us being quite defensive around that and kind of locking it down or numbing to it much like the patients probably do or have done. (Rose, p14)

Rose appeared to have become desensitised to the devastation that she was exposed to in this work and emotionally constricted to the effects of child abuse as she had become more accustomed to it. It can be interpreted that this had affected her insight and attunement to her own innermost thoughts and feelings, and affected her willingness to be emotionally open. This appeared to have formed a barrier to her ability to connect with her clients' stories as she no longer appeared appalled by them.

Participants discussed how this type of work could affect their frame of reference and they could start to feel hopeless and overwhelmed and start to lose perspective. These shifts were seen to reflect a profound loss of optimism and hope which participants were concerned could be transmitted to clients during therapy. Participants appeared to believe that this could have devastating implications and considered that could counter one of the aims of this type of work, which is to instil hope (Herman, 1992a).

You can become confluent with the client, so you can start to actually go, shit, you know, no wonder you're the way you are actually, and you can become really confluent, and you lose your position of perspective. (Charlie, p20)

Some participants discussed how they had started to become cynical through engaging in this type of work. They appeared to feel that cynicism developed gradually as a means of protection after being exposed to repeated disillusionment. Participants worried that this cynicism could convert them into becoming too hard and punitive and were concerned that this would have negative consequences for therapy.

You can easily become very cynical; you can become very punitive you can become very ground down working with this client group. (Kate, p31).

It appeared that some participants experienced similar signs and symptoms in themselves that their clients experienced, but at subclinical levels. As a consequence of working with traumatic material the changes that participants experienced within them appeared to at times colour their experience and perceptions about their own life experiences:

Initially I wanted to move to [place name], but generalised that the whole city was this hotbed of trauma, and I wouldn't be able to go out of the door without being exposed to it on a daily basis.., so it was less traumatic for me to spend 2 hours each way driving back and forth to [place name], and that's what I did, and actually that wasn't good for me. (Bob, p9)

It could be interpreted that as a consequence of involvement with high volumes of this type of work Bob experienced disruptions in his sense of safety. It appears he had started to display hyper-vigilance, a common symptom associated with exposure to trauma. This appears to have contributed to him viewing the whole of the city of [place name] being associated with trauma and basing some of his life decisions around this belief.

I think trauma can be transmitted from people, and I think horror and terror can be transmitted very very subtly between people, and it is more of the horror and terror than

the fear, the fear side of things, I think people that hold a lot of trauma within them, um, it can become transmitted in different ways very subtly, especially in something as powerful as the therapeutic relationship. (Charlie, p4 -5)

Most participants discussed what they considered the very real risk of becoming vicariously traumatised. They described how the palpability of a client's distress and the disruptions in their psychological systems could be brought into the helping relationship directly or indirectly through empathetic engagement with them. Thus it can be interpreted that although empathy is a quality essential to fostering a therapeutic relationship, it was paradoxically also experienced by some participants as a liability that could create trauma-related responses in them. Participants felt that the type of material they were exposed to in this type of work could be so disturbing that it caused them to feel an array of complex emotions including grief, anger, fear and rage. Kate discussed how in the context of this type of work her tears were very close to the surface and how at times she needed to release these powerful emotions:

I've got some patients where you know, I can weep after a session because I'm so moved or so touched by what they've told me cos it's just so awful. (Kate, p7).

Many participants felt that the impact of this work was not fully appreciated by the services that they worked within. They believed that they did not receive adequate levels of supervision in order to help them to cope with the demands they experienced in relation to this complex, specialist work:

Supervision, do we get the right supervision?.. em. Are our needs met in working with this extremely complex group? No, and these complex issues? no, absolutely not (Bob, p9).

All participants believed that it was not possible to do this type of work without experiencing assaults to their usual way of viewing the world and other people. Participants appeared to be effected by both the content of the material they were hearing and by the interpersonal process between themselves and clients. Experiencing disrupted beliefs and a variety of unpleasant responses was accepted to be part of the reality and process of this type of work.

3.7. Superordinate theme 6: Core role of therapeutic relationship.

This was a strong superordinate theme that emerged from all participants' accounts. For these clients, who participants perceived had grown up in families marked by conflict, abuse and interpersonal control, their capacity for developing and maintaining relationships was assumed to be highly negatively impacted. This was experienced as having significant implications for the role of the therapeutic relationship in this work. All participants believed that therapeutic relationship played a vital role in providing these clients with the support of a safe and dependable base that modelled healthy, non-abusive relationships within which to address, and work through the issues that lay at the heart of a history to complex trauma.

if you don't have the therapeutic relationship, I really don't think much else can move forward for that person, because you know we're talking about people who have got huge issues of attachment and huge difficulties generally in the relationships in their life.., so it's vital you know, that they get some experiences of be able to relate to people in a helpful way in a safe place. (Sharon, p11)

Many participants felt that one of the most important treatment tasks with these clients was to begin to replace their model of abuse-related relationships with patterns of interpersonal interactions that are mutual and collaborative. The therapeutic relationship was seen to provide a new model of relatedness that was a stark contrast to the abusive styles of relatedness that participants believed clients had previously experienced and come to expect. Participants assumed that this could potentially set clients on their way to believing that there was another way of being.

I think one of the things you're trying to em.., give them a positive experience of is relationships that differ from abusive relationships that they're likely to have experienced, I think that's where part of their healing is, within the relationship (Estelle, p13).

Participants perceived that a secure therapeutic relationship provided a corrective emotional and relational experience for clients and offered them an opportunity to revise their inner working models of attachment.

Developing a therapeutic relationship has been the cornerstone of him starting to attach to people in a more healthy way, or at all actually.' (Kate, p35)

Male participants felt that this was particularly challenging, yet important in their work with female clients who had frequently suffered abusive and violent experiences with men:

I think it's through her past male relationships that she's learned to distrust people and that the world's dangerous and threatening, and it's interesting to think that's it's a male relationship that she ends up then relearning over a period of time. (Tom, p7)

Tom appeared to believe that being able to understand and work through gender related dynamics could lead to a great deal to be gained from this gender difference. He perceived through his client tolerating the process of therapy he was able to offer her a different model for her interactions with men. Thus he conjectured this enabled her to challenge and restructure her beliefs about all men being violent and aggressive. Participants assumed that relational restructuring of their self to self and self to other occurred predominately through the interactive and experiential process of the therapeutic relationship.

There are inter-and intrapersonal relational difficulties, so it makes sense that part of the healing process, or the centre of the healing process is around helping them with interpersonal relational difficulties. The being with rather than doing to idea, and you can talk that concept to death, you know, and people do, but the lived experience of having gone through the relational experiences is the most, the most powerful thing you can have. It's the building blocks of human existence the building blocks of life. (Charlie, p24)

Thus it can be interpreted that participants assumed that the therapeutic relationship was both the process in which clients' relationship difficulties were experienced as well as the context in which they were explored and worked through. This is in keeping with the perspective of Courtois (2010) who states that '*the therapy relationship is itself the vehicle of change and the process in which change occurs*' (p 340).

I think the therapeutic relationship is more important working with complex trauma and substance misuse than elsewhere. Partly because the relationships, their models of relationships are generally so bad and relationships feel so risky, so taking the risk and going ahead with it, it's almost like a huge big giant painful experiment. (Louisa, p17-18)

It appeared that many participants perceived that when seeking psychological treatment these clients are faced with a painful dilemma - in order to recover from their comorbid substance misuse and complex trauma issues they must tolerate the risks involved and allow the development of a therapeutic relationship. Given the interpersonal nature of clients' difficulties and the betrayal that lies at the core of complex trauma, the role of the therapeutic relationship was considered by all participants to be a particularly important factor in therapy with these clients. It appeared that participants perceived that it is precisely *because* relationships seem so threatening and challenging for these clients, that development of the therapeutic relationship forms such a vital part of therapy and of their recovery process. It can be interpreted that Louisa assumed that in a behavioural way the therapeutic relationship can function as a source of *in vivo* exposure for these clients, whose difficulties frequently lie in the avoidance of intimacy and not trusting others. Thus the risk involved in the therapeutic relationship for these clients could be considered a creative risk.

The majority of participants perceived that if they were able to establish a safe and containing relationship then this in itself could model and help to teach emotional regulation techniques. Participants perceived that this was the foundation upon which behavioural change and symptom reduction was predicated.

I've found that I've got one guy who's been an absolutely prolific self-harmer and within about ten sessions he'd stopped, and I hadn't done anything, I hadn't, you know, he'd previously had, he'd previously learnt other strategies, taking cold showers, using ice cubes to stop himself from cutting, we'd not actually gone over any of that, but he was just feeling like somebody was listening and somebody was there and somebody was understanding, so he'd stopped cutting (Kate, p26)

Kate assumed that this client's self-harming behaviour settled down by itself as a consequence of a positive therapeutic relationship. It appeared Kate thought this had happened as a consequence of the client no longer feeling left alone with feelings that he could not manage. Most participants perceived that complex trauma was what bad relationships do for clients, thus they conjectured that it made sense that a good relationship could be an integral part of treatment. This corresponds with Kinsler *et al.*, (2009) perspective that '*victimised children are hurt in relationships, yet paradoxically, relationships can be the core component of healing from these injuries*' (p 183).

Participants perceived that the therapeutic relationship was where and how the recovery of these clients really happened. Thus it was perceived as both the technique and relationship in which this treatment took place:

The therapeutic relationship is the most important thing.; everything else comes second to it. (Bob, p17)

I can remember when I just starting training having a sense of like, so initial work is building a therapeutic relationship and then we'll do this., but actually it IS the work with these clients. (Sharon, p11)

I think the whole idea of recovery can be too quickly seen as someone getting off a substance, but actually it's all about what happens in the relationship, it is where they get their recovery and also where they get their relief in their recovery and the chances of hope of being different and seeing things differently. And having you believe in them and being able for that hope to be held and worked through and shared. I think that's where change stems from, through the process, not in the actions or the content of what we do. (Rose, p15-16).

4 Reflections

Within IPA, it is recommended that researchers clearly reflect upon their position within the research process (Smith *et al.*, 2009; Willig, 2001). This endeavour not only helps with the transparency of the results but also makes the reader aware of the ways in which the researcher's experiences, beliefs, theoretical stance and personal identity may have influences the research. For this reason, the researcher kept a reflective diary throughout the study to record any experiences during the research process, including reactions to participant's interviews, and the process of transcribing and analysing. The subsequent section is written in the first person and contains extracts from the researcher's reflective diary:

Complex trauma is a difficult to pin down; it is a diffuse term and covers a range of experiences predominantly relating to trauma that has been experienced in childhood or adolescence, but not exclusively so. I have found that although the concept of complex trauma is recognised in a great deal of the literature, in some instances it seems to be a term that people are not familiar with. It seems that a lot of people think of trauma and automatically think PTSD- avoidance, hyper arousal and re-experiencing and that's where it ends. When trying to get this project started and the idea for it accepted as a viable project the whole notion of complex trauma and its lack of recognition in medical diagnostic categories became problematical:

'Had a meeting at the uni today, feel like I am never going to get my idea off the ground. It seems like everyone wants me to focus on a particular comorbid issue i.e. PTSD as defined by the diagnostic category, CSA or CPA- what I am trying to convey is that that is precisely what I don't want to do as these discrete categories are not the reality of what I see in my day to day work with this population. I know that other people know that and they are just trying to make the process more straightforward and organised, however I want to try and remain true to this messier picture. I feel these clients' real life experiences reflect a mixture of multiple traumas all mixed together and then made worse by their substance misuse. It feels like in research and in practice we try separate these experiences in order to organise and get our heads around them, however they are not separate in clients real life

experiences and this is why I am so keen to not go down the route of looking at one specific disorder/ type of abuse or another' (Extract 1).

There were many times, particularly early in the study where I felt constrained by language and felt that I could not find the words to communicate what I was trying to:

*'Today I got into a conversation about why complex trauma can result in more complex sequelae than single incident trauma, despite the fact that unlike the diagnosis of PTSD it does not have to include situations where the individual may be at risk of death. I ended up comparing complex trauma with the concept of 'psychic death', this resulted in **** bursting into laughter at this term I had picked from the sky (as I joined in). However, after I left the conversation I kept returning to it in my head. I began to realise that although it sounded pretty ridiculous at the time, in some ways 'psychic death' was actually an apt description of what I was trying to get across!' (Extract 2).*

Carrying out the interviews and listening to other psychologist's stories made me reflect on my own practice and I felt in one of the ways that many participants described their practice and ideas about work with this client group.

'I have just finished my fifth interview and I am totally enjoying this experience and I getting to go to parts of Scotland that I have never been before and meeting some really interesting and wise psychologists. I feel that there is a great deal of knowledge being imparted to me during this process and I feel lucky that I am getting the opportunity to do it. In fact part of me wants to expand this project and go all over Britain interviewing substance misuse psychologists and their perspectives and experiences of working with complex trauma (I have to stop getting carried away here!). One very simple but valuable thing I have discovered though is the power of a cup of coffee and a comfortable chair. This appears to have the desired effect of putting the participants at ease. On the one occasion that a hot drink was not brought into the interview by the participant, I feel that the interview did not go nearly so well.' (Extract 3).

Sometimes the issues that people subtly conveyed resonated with some of my own experiences and I times it stirred up issues from the past which had frustrated me:

'It is really interesting to hear the perspectives of psychologists across different services and has highlighted for me how important the perspective of the psychologist who is managing

the service is for the type, and in my opinion quality of care that clients receive. I understand this is a bit of a contentious issue, but I feel that I am picking up from the participants that I am interviewing that some managers do not like the idea of working with substance misusers with complex trauma histories and try to play down how prevalent this issue is amongst substance misuse clients. I can understand that these clients require a great deal of time and energy to work with and that there are many pressures for throughput etc. However, it appears to me that the psychologists working with these clients know that if they are treated only quickly and superficially, and their core issues with relating to others are not addressed, they will quickly end up back in services again. Surely in the long run it would be better for everyone (and more economical), if their issues were adequately addressed the first time around?’ (Extract 4).

As I began my first analysis, I felt really apprehensive due to my inexperience with qualitative research and IPA. However, I took comfort in and felt reassured with the step by step process of analysis as set out by Smith *et al.* (2009) and this became my bible.

‘I have just finished analysing my first transcript and I really found the whole process very bizarre and completely different from anything I have done before, I keep wanting to know if I have done it right, however I know there is no such thing as the right way to do it. Its really rather anxiety provoking.’ (Extract 5)

As recommended by Yardley (2008), I acknowledge how my position as the researcher may have impacted on the analysis process- with both a professional and professional interest in working with clients with substance misuse and complex trauma histories.

5 Discussion

5.1 Summary of Main Findings

Six main superordinate themes emerged from the data: 1. Challenges in negotiating therapeutic relationship; 2. Balancing relational forces; 3. Walking the tightrope of comorbidity; 4. Conceptual dearth (surrounding complex trauma); 5. Emotional impact of Work, and, 6. Core role of therapeutic relationship (in treatment and recovery). The extensive implications of complex trauma on later attachments and/or relationships have been the focus of several studies over the last twenty years (Beck *et al.*, 2009; Fonagy & Bateman, 2008; Lyons-Ruth & Jacobitz, 1999). However, qualitative research that gives voice to the quandaries and complications of negotiating therapeutic relationships with these clients has been limited. This study was interested in making visible the challenges and experiences of psychologists in their work with substances misuses with histories of complex trauma. The limited research addressing the perspectives of professionals and clients within this area meant that it was challenging to compare, evaluate and contextualise the present findings.

Some findings in this study correspond with previous research and some new issues have been identified. According to Parker (2005) the aim of qualitative research is not to give a series of finite results but to offer an analysis which focuses on the ways in which meaningful qualities of human experience are represented. In so doing, different perspectives can be brought into being and further questions opened up to enquiry. Throughout this study participants discussed their experiences of certain topics that were not particularly amenable to research. For example, it is difficult to accurately examine intra-psychic processes and relational dynamics, which were often played out on an implicit and unconscious level and were sometimes hard to grasp. The researcher was only able to access these through how the participants talked about and perceived them. This study was not claiming to get to the route of these processes, but instead was looking at researchers perspectives about their experiences of work with this client group, as well as the researcher's interpretations of this.

The following section offers a broad discussion of the main research findings. While the previous section of this study (the analysis) aimed to stay close to the participant text, this

section departs to some extent from that position and discusses some of the findings suggested by participant's narratives within the context of existing literature. Due to space limitations the discussion was not able to focus as extensively as the researcher would have liked on all the findings of the current study, instead it was required to focus on what were considered the most salient issues arising from the analysis. Findings relating to themes that were not directly reflected on have been incorporated into the section discussing the implications of the findings. The reflections on themes follow a different order to that laid out in the results, which highlights the fluid and complex nature of the connections between themes. It is important to note that although the researcher wanted to avoid certain terms which are connected with particular paradigms of psychology, at times this was felt to be unavoidable.

As has been found in previous research, the psychologists in this study perceived that problems experienced by clients with substance misuse difficulties and histories of complex trauma were frequently more intense and more difficult to address than those of other clients that they worked with (Najavits, 2002a; Fahy, 2007; Ford *et al.*, 2007). These client's difficulties were perceived to be fundamentally connected to and influenced by their difficulties with attachment, relationships and relating to others. Participants believed that many of these difficulties could be traced back to their childhood experiences of interpersonal abuse or neglect and were magnified further by their difficulties with substance misuse. Participants described many potential pitfalls and paradoxes inherent in their work with this population.

5.2 Reflections on main findings

5.2.1 Reflections upon mistrust as a barrier

Participants perceived that through their complex trauma and substance misuse histories many of these clients had learnt to approach others with mistrust, which created barriers to the development of a collaborative therapeutic relationship. They assumed clients often struggled with taking the emotional risk required to reach normal levels of trust within the therapeutic relationship. This corresponds with the findings of a number of clinicians and researchers who have observed that adult survivors of complex trauma struggle with trusting the therapist, as well as identifying deficits in their ability to stay connected in the therapeutic relationship (Beck *et al.*, 2009; Beitchman *et al.*, 1992; Davies & Frawley, 1994;

Janoff-Bulman, 1992; Kinsler, *et al.*, 2009). In accordance with previous findings negotiating a trusting therapeutic relationship was experienced by these participants as developing within the context of relational testing (Kinsler *et al.*, 2009). Participants perceived that the trust that arises in the therapeutic relationship with these clients was hard-earned and required a considerable amount of time to develop (Chu, 2011).

Davies & Frawley (1992) and Hegeman (1995) suggest that attention must be paid early in therapy to enhancing client's trust and ability to relate. They propose that traumatic histories can only be addressed and re-written if the patient and therapist are able to form a trusting and intimate relationship. Developmentally, establishing basic trust is considered one of the first prerequisites for healthy personality formation. Indeed, in Erickson's (1963) theory of human development, the first psychosocial crises all humans encounter is the trust vs. mistrust conflict. Participants deemed one of their main aims of therapy with this client group was to help clients to reconstruct their sense of selves and their modes of relating. This fits with Erickson's (1963) theory, and can help explain why trust is a particularly important foundation upon which to build the therapeutic relationship with this client group. According to Erickson's (1963) theory, the normal stage of developing trust begins at birth and continues as a major life focus until approximately one and a half years old (although this varies from person to person). The psychologists in this study assumed these clients have frequently not had predictable and consistent responses from their primary caregivers and have therefore have not had the opportunity to develop trust, instead they have learnt to mistrust (Leehan & Wilson, 1985). This could be conjectured to offer one hypothesis to help explain why some psychologists in this study felt pulled into adopting a parenting stance with these clients. If some of these clients have never accomplished this early developmental task, then aiming to develop their capacity for trust (as had already been discussed) becomes an important part of the therapeutic process. In this endeavour it is easy to see how the therapist may come represent a transferential parent figure.

5.2.2 Reflections on tensions inherent in assuming parenting role

In their work with substance misusers with complex trauma histories Evans and Sullivan (1995) advocate that transference phenomenon can be better understood when therapists become aware that at times they will become a parental figure for these clients who may

age-regress during sessions due to the reactivation of developmentally- based issues during sessions. Kohlenburg and Tsai (1998) also consider that the relationship between a therapist and client captures many essential elements of the parent-child relationship and emphasise that because of this it has great potential for both harm and healing. In the present study there was no consensus among participants about whether adopting a parenting stance was advisable or not, rather it appeared to depend upon the individual perspective of the psychologist. Although some participants believed that adopting this role could be beneficial for the progression of therapy, others felt that it carried with it particular risks and should be avoided. This tension is reflected to some degree in the literature, for example Dozier & Tyrrell (1998) propose that from an attachment theory perspective, therapists work with their clients should be similar to that of a mother with her infant. However, Cheftetz (1997) cautions therapists about getting caught in the position of trying to prove themselves better than the abusive and neglectful others in the client's life.

5.2.3 Reflections on promoting consistency and boundaries

Promoting boundaries and consistency emerged as a theme from the analysis. Boundaries were considered to be subjective but consistency was held to be paramount. Participants discussed how they endeavoured to provide consistency with regard to their balanced and predictable responsiveness, length of sessions and appointment times (trying to have appointments at the same time and day each week). Consistency has been described as an essential element of healing with survivors of complex trauma (Kinsler *et al.*, 2009). Participants were aware of the enormous harm that could be done to clients by overstepping boundaries, and appeared to work on the principle of 'do no more harm' (Courtois, 1999). Male participants were brave and open with respect to the rather taboo subject of the tendency for female clients who have been sexually abused to try to use their sexuality as a means of forming a relationship with them, and reflected up how this transference could bring a seductive element to the therapeutic relationship. They perceived that openness and discussion of this issue was essential. The literature is unfortunately replete with examples of cases where this difficult issue was clearly not openly examined or adequately addressed and both female and male therapists have engaged in sexual relations these vulnerable clients (Gabbard, 1989; Kluft, 1990; Lymberis, 1994). As well as highlighting the important need for boundaries and consistency, the psychologists were also concerned about the potentially damaging effect of boundaries

that are inflexible. Participants perceived that if boundaries were too rigid, the flexibility necessary to navigate the vicissitudes of the therapeutic relationship may be lost, and clients may struggle to adapt to services as they are currently set up. This perception is not proportionately reflected in the existing literature. Instead with respect to traumatised clients there is far greater focus upon the risk of overstepping boundaries, with much less attention given to the potential detrimental effect of boundaries that are narrow and non-negotiable (Kinsler, 1992).

5.2.4 Reflections on relationships and risk

Psychologists in this study perceived that relationships in general are perceived to be risky by this client group. Dalenburg (2000) highlights how the interpersonal beliefs and choices made in the past by survivors of child abuse may have saved them from significant harm. Thus suggesting their schemas about self and others and their internal working model (Bowlby, 1969) are particularly resistant to revision. Attaching to a psychologist within the therapeutic relationship was assumed by participants to be a dangerous place for these clients. This corresponds with Spiegel's (1986) comments about working with adult survivors of childhood trauma: *'the patient unconsciously expects that the therapist, despite overt helpfulness and concern, will covertly exploit the patient for his or her own narcissistic gratification.'* (p72). Psychologists within this study found the task of helping clients to convince themselves to risk entering the 'safe' therapeutic relationship was particularly challenging. Most recognised that no matter how compassionate and empathetic they were they would be likely to find themselves the objects of 'traumatic transferences' (Spiegel & Spiegel, 1986). However a minority of participants appeared to struggle with not being seen as positive and helpful.

5.2.5 Reflections on push and pull dynamics

Relational dynamics were considered by the psychologists in this study to be co-constructed between themselves and the client. They experienced that clients core relational difficulties and cognitive and emotional 'lessons of abuse' (Courtois, 2010, p339) were often brought into the therapeutic relationship. One theme which related to this was 'push and pull dynamics'. Chu (2011) also observed similar *'intense approach-avoidance dynamics'* (p68) in his work with clients with complex trauma histories. Like the psychologists in this study, Chu (2011) conceptualised these dynamics as a recapitulation of

a client's earlier patterns of disorganised attachment re-enacted within the therapeutic relationship. In an earlier article Chu (1988) wrote about the challenging and turbulent therapeutic relationships frequently formed with traumatised clients, and of the treatment traps (including mistrust and neediness) which therapists need to be aware of, and prepared for in this work.

5.2.6 Reflection upon recognising own reactions

Many participants perceived that these dynamics were not simply a complication within the treatment process but an opportunity to gain greater insights into client's' dilemmas. Participants appeared to work creatively with these dynamics so that they could be used to assist the advancement of the therapeutic process. Thus participants perceived these dynamics provided powerful indications about what was being experienced by the client at the time. This corresponds with Bromberg (1995) who described how countertransference reactions can provide a *'powerful on-going source of data - a forced invitation into the patient's world'* (Bromberg, 1995, p148). Gartner (1999) highlighted how transferential enactments in the therapeutic relationship can help clients to communicate what has previously been unarticulated. He conjectured that when a dynamic is transmitted behaviourally, the client and therapist together can analyse the live interactions between them. In doing so he proposed they have the opportunity to transform previously unspoken messages into verbal ones that are available to consciousness.

5.2.7 Reflections on risks integral to this work

The psychologists in the current study discussed the many challenges pertaining to risk that were inherent to their work with this comorbid client group. These challenges have been discussed by previous researchers and clinicians (Evans & Sullivan, 1995; Sterman, 2006). The psychologists in this study experienced the decision whether or not to engage with trauma processing work with these clients was a very anxiety-provoking one. They deemed that that complex nature of these client's trauma histories, and the consequential diffuse, difficult to describe and multiple memories of trauma, combined with their substance misuse difficulties, were potential contraindications for trauma-processing work. The research literature concerning trauma-processing predominately relates to 'simple PTSD/trauma'. There has been very little research which has examined trauma-processing with more complex traumatic presentations, the limited ones which have demonstrate that

in the absence of adequate preparation trauma-processing can become counter-productive and destabilising (Gold & Brown, 1997). Some research examining trauma-processing as part of substance misuse treatment has found that it has the propensity to jeopardise a client's well-being by triggering a relapse of substance misuse (Pitman *et al.*, 1991; Triffelman *et al.*, 1999). In research with substance misusers with histories of trauma Dansky & Brady (1998) found that although those who engaged with trauma processing had positive outcomes, many were unable to do so. Another study which showed successful results for trauma-processing work was conducted in the environment of a substance use residential facility (Henslee & Coffey, 2010). Clients in this study had on-going access to support and were living within a substance-free controlled setting. This environment was very different from the outpatient services in which the participants in this study worked. Attachment theory would suggest that a singular focus on the processing of abuse in therapy would not automatically change a client's internal working models of relationships and therefore not promote recovery. The findings from this study appear to lend support to this notion.

5.2.8 Reflections on fundamental relationship to attachment difficulties.

In 1952 Fairburn put forward the notion that it is the desire for a relationship which is at the heart of being human. In a similar vein Gelina (1983) highlighted how in her experience, individuals seeking treatment after incest did so because of the consequences of the impact on their relational life. Thus she perceived that difficulties in relationships with others were frequently the main motivation for these clients to seek treatment. While Gelina (1983) refers specifically to survivors of incest, other authors have discussed similar perspectives in relation to other types of complex trauma (Chu, 2011; Kinsler *et al.*, 2009; Kohlenberg *et al.*, 2006; Saakvitne *et al.*, 2000). In a study with adults who had been maltreated Muller & Lemieux (2000) found a significant relationship between lack of social support and increased psychopathology. Similarly, the findings of this current study highlight how psychologists perceived there to be a fundamental connection between clients' presenting problems and their difficulties with attachment relationships. A history of complex trauma is accepted as decreasing an individual's ability to form and maintain secure attachment bonds and increase their vulnerability to becoming addicted to substances (Potter-Efron, 2006). Flores (2004, p7) states that '*Individuals who have*

difficulty establishing emotionally regulating attachments are more inclined to substitute drugs and alcohol for their deficiency in intimacy.'

In a multi-method study looking at women's experiences of recovery from complex trauma (Banyard & Williams, 2007) found that women described relationships with others as being sources of motivation which aided the process of recovery in their lives. A large proportion of the women also had significant substance misuse issues. An interesting finding from this study, supported by the findings of the current study, was that women's recovery from their complex trauma histories and substance misuse difficulties appeared to co-occur. These women gradually discerned over time that substances could not mask the pain of their abuse. In fact it was building new relationships and connections that helped them to change previous maladaptive patterns of behaviour. Recovery from complex trauma and from substance misuse has separately been proposed to involve the survivor's creation of positive and meaningful connections (Herman, 1992; Flores, 2004). This principle also seems to apply when these difficulties are co-occurring.

5.2.9 Reflections on core role of therapeutic relationship (in treatment and recovery)

Participant's' perception of the core role of the therapeutic relationship in the treatment and recovery of these clients emerged from the analysis as a central theme. This corresponds with a long line of research which suggests that the therapeutic relationship contributes more to successful therapy than technique or strategy, regardless of which paradigm is being considered (Horvath & Symonds, 1991; Lambert & Barley, 2001; 2002). However, the pervasiveness of disordered attachment in the aetiology and manifestation of client's complex trauma related difficulties led participants to believe the therapeutic relationship had a particularly central role in the psychological treatment of them. This perspective has been supported by empirical findings - Pavio, Holoway & Hall (2004) demonstrated that in a population of adults abused as children, therapist relationship skills significantly contributed to outcome. Thus the therapeutic relationship was identified as being an important mechanism of change.

Cloitre Stovall-McClough *et al.*, (2004) found that the therapeutic relationship was a vital component in the treatment of complex trauma, the effects of which were mediated via the modelling and teaching of emotion regulation. Their findings correlate with social

development literature which denotes that the learning of emotion regulation skills is strongly influenced by an individual's interpersonal relationships and contexts (Hofer, 1994). Cloitre *et al.*, (2004) found that the effect size between the therapeutic relationship and positive treatment outcome for survivors of complex trauma was more than twice as large (.47), as that which had been observed in previous meta-analyses of other populations (.20 and .22 respectively) (Horvath & Symonds, 1991; Martin, Garske & Davis, 2000). These researchers concluded that the therapeutic relationship may be a particularly 'active' ingredient in the treatment of complex trauma, due to the interpersonal context in which the trauma took place (Cloitre, *et al.*, 2004). Supporting the assumptions of psychologists in this current study, Cloitre *et al.*, (2004) suggested that the therapeutic relationship provided an opportunity and a context in which survivors of complex trauma could learn about and express emotions and how to manage them. Pearlman and Courtois (2005) propose that relational and self-related difficulties:- *'that many complex trauma survivors experience can be addressed through the therapeutic relationship which becomes both the "testing ground" for the emergence of these issues and the context in which they are experienced, explored, shared, understood and ultimately resolved.'* (p450)

The author was not aware of any research exploring the role of the therapeutic relationship in the treatment of substance misusers with co-occurring histories of complex trauma. However, it has been established within substance misuse treatment that the therapeutic relationship plays a significant role in treatment engagement, retention and early improvement in treatment (Meier *et al.*, 2005). Empirical studies have also suggested that therapists appear to have more impact on outcome than either the type of treatment or the baseline characteristics (Najavits, Crits-Christoph *et al.*, 2000; Project Match Research Group 1998; Luborsky *et al.*, 1997). These findings together lend empirical support to the perspectives of the psychologists in this study - that the therapeutic relationship plays a core role in the treatment and recovery of these comorbid clients.

In contrast to survivors of circumscribed trauma where a client's consequential avoidance may relate to specific stimuli (for example avoiding entering a car after a road traffic accident), Kohlenburg & Tsai (1998) have proposed that the main difficulties for survivors of complex trauma are relationships and intimacy, with not having a sense of self and not trusting others. Kohlenburg *et al.*, (2006) suggest that when a client who has experienced complex trauma enters into a therapeutic relationship, many of the issues which he or she

finds difficult are likely to arise within the therapeutic relationship. They advocate that one of the reasons that the therapeutic relationship may play such a core role in the treatment of individuals with complex trauma is that these relationship-related difficulties can be dealt with *using* the therapeutic relationship. Thus the therapeutic relationship is seen provide a source of *in vivo* exposure and the opportunity to block avoidance (Kohlenberg & Tsai, 1998; Kohlenberg *et al.*, 2006). In the current study their theory can be seen to correlate with Louisa's comments where she compared the risk that clients take in entering the therapeutic relationship to a '*huge big giant painful experiment.*' Kohlenberg and Tsai (1991) propose the use of Functional Analytic Psychotherapy (FAP) with this traumatised client group, which is a radical behaviourally- informed treatment devised to account theoretically for the powerful and widespread improvements demonstrated by some clients after involvement in therapeutic relationships.

The psychologists in this study perceived that a core part of their work with this client group was to provide the relational conditions in order to help encourage the trust and attachment between themselves and the client. It was through such conditions that they perceived clients can change their attachment styles. Bowlby (1988) proposed that altering inner working models within the therapeutic relationship involves investigating clients' expectations of the therapists and significant others. Research has suggested that attachment styles are dynamic in nature, have the potential to change with new life experiences and relationships (McLewin & Muller, 2006). Schore (2003a) and Siegal (1999) went as far as to propose that attachment styles can overtime be changed from insecure and disorganised to secure. Participants in this study were aiming for clients to move towards what has been termed an *earned secure* style within therapy and their recovery which was then hoped to be extended to extra-therapeutic relationships (Valory, 2007). Some clinicians and researchers have proposed that psychotherapy can function as a "recovery environment" (Johnson & Williams-Keeler, 1998) as frequently it is the only accessible context in which survivors of complex trauma can discuss their history of trauma. Psychologists in this study conceptualised recovery as a dynamic process in which they endeavoured to bear witness to their client's' trauma histories and to help instil hope for their clients. They, like others (Herman, 1992) perceived this played a core role in the healing of the relational difficulties connected to client's complex trauma histories.

There are clearly a number of overlapping theories in the literature offering theories to explain the role of the therapeutic relationship in the treatment of individuals with histories of complex trauma. However, in keeping with the perspectives of the psychologist in this study there is empirical evidence and clinical consensus to support that the therapeutic relationship plays a particularly core role in the treatment of this client group (Courtois, 1999; 2010; Pearlman & Saakvitne, 1995; Saakvitne *et al.*, 2000).

5.3 Reflections on the use of IPA

IPA was a pragmatic choice for this study. It has allowed a consideration of a small number of participant's accounts in some depth and has enabled an open exploration of participant's subjective experience. However IPA has also entailed some limitations.

5.3.1 Limitations of the use of IPA

A criticism that has been made of IPA is that it takes a naïve view of language, that is, IPA tends to treat language as though it was a purely descriptive entity rather than a performative process which actively constructs objects, subjects and persons (see Willig, 2001). Against this, Smith (1995) has proposed that IPA is a method which maintains sensitivity to language and context and which can incorporate both a social cognition and discursive view of persons. Yet in conducting this study, it has seemed that the techniques and conventions of IPA have tended to marginalise language as an issue. There were times during the research where the IPA analysis seemed out of keeping with the text under consideration and that the large amount of data produced by this study, compromised detail. The researcher was drawn to each individual text and the rich data promised there, yet compromised by the demands of the overall analysis. However there are always compromises in the choice of method, and overall IPA suited the purposes of this study well.

5.3.2 Implications for clinical practice, service delivery & research:

A growing body of evidence suggests that persons with co-occurring mental health and substance misuse difficulties are not well served in existing systems of care (Wu *et al.*, 2003). Substance misuse services which fully incorporate client's early traumatic

experiences in the conceptualisation of their problems and accommodate their difficulties with issues - such as lack of trust, fear of relationships, lack of attachment relationships and boundary-related issues - are needed in order to adequately meet the needs of this client group. However, the lack of evidence base and the conceptual understanding of complex trauma within wider multi-disciplinary substance misuse teams suggest that psychologists are not adequately supported, given enough time, and their efforts are not fully understood in their work with this client group. Substance misuse services need to become more trauma-informed, and incorporate more comprehensive understanding of what integrated working entails in order for the needs of this group of vulnerable clients to be adequately accommodated within services.

Traditionally substance misuse psychology services have looked towards an evidence base in which a cognitive behavioural and motivational interviewing (MI) evidence base has been given predominance due to the success of these approaches in dealing with substance misuse difficulties. Psychologists in this study felt they needed to draw on other theoretical perspectives out-with CBT and MI where cases involved clients with comorbid complex trauma histories. As has been noted by Courtois (2002) psychologists in this study felt that training around working with survivors of complex trauma had been poorly integrated into their professional training. This has implications for CPD which needs to address these training issues and suggests that more clinical innovation and research are needed to continue to develop the best-practice models for clients with complex trauma histories.

Working with substance misusers with histories of complex trauma elicits strong feelings and reactions in both client and therapist. The psychologists in this study were not working in a vacuum and they needed to be supported to achieve balance in their work and personal lives. Some of the most basic ways that substance misuse services can help to balance the challenges of working with this client group relate to case size and a balance of cases, as well as clinical supervision. Unfortunately many of the participants in this study felt that they were not given adequate supervision or support with respect to this work. Policy that is aware of the difficult nature of working with this comorbid client group, as well as training that addresses the impact of this work is required if psychologists (and other professionals) are to cope with this type of work and not become burnt out, cynical or even vicariously traumatised

Recent years have brought with them a large push for “empirically validated treatments.” Research in psychotherapy effectiveness has focused upon treatment based upon manual-based protocols (Binder, 2004), which are designed to eliminate differences between therapists. However, the findings of this study combined with a long line of research suggest that it is in fact these idiosyncratic therapeutic relational difficulties - a part of every treatment relationship - which influence and predict outcome (Hubble *et al.*, 1999). The findings from this study suggest more research and attention needs to be given to relational approaches and there should be greater examination of the interactive components of therapy if substance misuse services are to move towards understanding what is happening dynamically within the relationship that enables change. Psychologists could play a key role in this.

5.4 Strengths of the current study

‘The necessary components of the therapeutic relationship in the recovery of interpersonally traumatised individuals.. require(s) on-going articulation and research substantiation’ (Bessel *et al.*, 2005, p 358).

This study attempted to go some way in helping to address the above suggestion and focused on a subject area which has been frequently misunderstood and under-represented in the research literature. To the researchers knowledge it is the first study to address the experiences and perspectives of professionals working with substance misusers with histories of complex trauma. Complex trauma is difficult to conceptualise and define and its sequelae are heterogeneous, which it can be hypothesised are the main reasons why there is a limited evidence base connected to it. Using qualitative methodology allowed an exploration of the complexities involved in working with comorbid client group. Quantitative methods would not have been able to elicit such rich and meaningful data and would have missed many of the nuances and subtleties allowed by this type of research.

In a frank discussion of psychotherapy research Orkinsky (2006) discussed how in practice the standard research model implicitly defines treatment as a unidirectional process, where therapists are presumed to be active subjects and clients are presumed to be reactive objects. He commented that *‘the dominant research paradigm seriously distorts the real nature of person’s and psychotherapy’* (p2) and went on to argue that research to be based upon a paradigm which more satisfactorily corresponds to the real experience and lived

reality of what it claims to study. Although Orkinsky (2006) did not specify or predict what this research paradigm would turn out to be, this study has attempted to move away from the traditional research paradigm and has endeavoured to try and incorporate some of what the researcher interpreted Orkinsky's (2006) to mean.

5.4.1 Limitation of the current study

Information was not collected about the psychologist's theoretical affiliation, experience, training and supervision arrangements. Information on the exact nature of the complex trauma histories of clients was also not collected. It was decided that requesting such information would have been considered too intrusive and too identifiable (within the relatively small numbers of psychologists working in substance misuse services in Central Scotland) and there was a concern that this could potentially affect the acceptability of research by these psychologists.

Despite many practitioners' claims to mutuality in the relationship with their clients, very little research has followed this line of enquiry. Feltham (1999) highlights how the majority of accounts of the therapeutic relationship are written by the therapists themselves and this may distort practice. In this study the psychologist's experience of therapy may have been very different from their client's experience and caution must be taken in the interpretation of these results to accommodate this bias. Also, the subsample of psychologists consisted predominately of females. This may have been likely to reflect actual gender proportions within clinical and counselling psychology. However despite this it means that gender bias cannot be ruled out.

Holloway & Jefferson (2000) discuss the 'defended subject' (p59), by which they are referring to the tendency for people, in general, to provide self-defensive accounts of their lives as this is how they choose to see themselves. This can result in a disparity between overt speech and covert cognitions of emotions. Defended-ness may have been a factor for some participants, particularly in light of the fact that substance misuse psychology is a relatively small specialism and they may have been reluctant to be open about their true opinions. It is also important to view the interviewer themselves as a defended subject (Holloway & Jefferson, 2000) who will have fashioned, interpreted and presented the data in a particular manner according to their own self-defensive beliefs. One of the advantages of IPA, however, is the explicit recognition of this interpretation, and the effort to separate

the voice of the researcher from those of the participants throughout the analysis (Smith *et al.*, 2009).

The overall generalisability of qualitative studies is always limited due to the small number of participants, thus the generalizability of this study's findings needs to be approached with caution. These findings, however, provide valuable theoretical generalisation, in that they broaden our understanding of some of the issues which may be present for psychologists working in similar services. For example the current study is relevant to the wide variety of mental health arenas where clients with complex trauma histories present. Some of the issues identified in this study are undoubtedly relevant for psychologists working with clients with complex trauma-out with substance misuse services. These findings have contributed towards building an evidence base for this under researched area.

5.4.2 Future Research

There is a wealth of future research that would be useful within this area. In terms of further qualitative research, it would be interesting to explore the perspectives and experiences of clients who have substance misuse issues and histories of complex trauma. It would be interesting to gauge how their perceptions differ and converge with the psychologists (and other professionals) who are working with them. It would be useful to identify any changes that clients feel could be made to improve current styles of working to better accommodate their needs.

As previously discussed, quantitative and qualitative research methods are best used jointly. It would be useful if quantitative research could explore some of the ideas discussed here, which would help to generalise findings. It would be interesting to examine how many clients attending substance misuse psychology services in Scotland, and perhaps across the UK, have histories of complex trauma. Within this group it would be beneficial to know how many sessions these clients generally receive within substance misuse psychology services, how many of clients proceed with trauma-processing and the outcomes of this and the impact of therapy on clients relationships out with the service. It would also be useful to measure the strength of the therapeutic relationship and degree of trust clients feel towards their psychologists and examine how these impact upon treatment and outcome need. Further research would also be helpful in considering the

type and training and supervision that would be most useful for psychologists working with these clients, exploring the impact of different types of training and supervision on psychologist's burn-out rates, vicarious traumatisation and client's satisfaction with the service.

5.4.3 Summary and Conclusion

Using an IPA approach, the experiences of eleven psychologists working in substance misuse psychology services with clients with histories of complex trauma throughout Central Scotland were explored. Accounts were rich and insightful and allowed poignant conclusions to be drawn about the factors which need to be taken into consideration in work with this client group, as well as the present restrictions within services which may limit the effectiveness of treatment options and outcomes for this client group.

Following the recognition of the large amount of individuals with histories of complex trauma within the current mental health system- particularly in certain populations such as substance misusers- it has become clear that there is a need to review how best to work with these individuals. Currently the sequelae of complex trauma and the complex relationship between a history of complex trauma and substance misuse difficulties appear to not be fully understood within substance misuse services. It is hoped that with the addition of complex PTSD to DSM V and the drive for trauma-informed services, this will change over time. As clients' presentations become more complicated with the presence of comorbid substance misuse and histories of complex trauma, treatment generally becomes more formulation and relationship based with less emphasis being placed upon treatment modality. The nature of a history of complex trauma means that often clients have difficulties with attachment and relational aspects in their lives, which in turn affect their engagement in the therapeutic relationship. The findings of this study suggest that it is precisely *because* relationships seem so threatening and challenging for these clients, that the therapeutic relationship appears to form such a vital role in the therapeutic treatment and recovery process for these clients. This combined with the restrictions on the available evidence base and treatment options for these patients lends support to the suggestion that treatment approaches that use a relational framework may be particularly relevant to clients with comorbid substance misuse and complex trauma-related issues. Psychologists play a key role in the treatment of these comorbid clients and the findings of

this study suggest that they can create a theoretical and practical bridge between the worlds of substance misuse and complex trauma treatment. The findings of this study indicate the need for further research in this area.

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